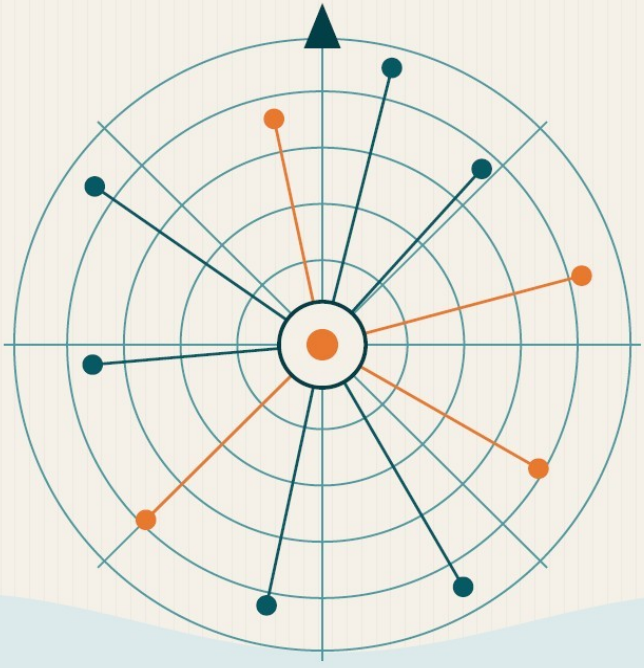
QUIET HARBOUR HOUSE

# THE SAS DOCTORS HANDBOOK

## A Practical Guide to Careers, Contracts and Professional Life in the NHS



EVIDENCE
DECISIONS
OPPORTUNITY
A STRONGER NHS

CAREERS
CONTRACTS
LEADERSHIP
A SUSTAINABLE FUTURE

DR NAEEM AZIZ DGM FRCP

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This handbook provides professional education and general information. It does not provide advice on an individual clinical case, employment dispute, regulatory proceeding, immigration application, investment, pension or tax decision. The relevant current rules, contractual terms and circumstances govern each situation. Obtain advice from a suitably qualified professional when the consequences require an individual assessment.

The clinical and workplace examples are composites created to explain common professional decisions. Names, settings and circumstances do not identify particular patients, colleagues, employers or proceedings. An outcome described in an example does not establish a precedent or predict what another organisation will decide.

Sources were checked through 12 September 2026. National policies, contractual documents and administrative arrangements can change. Publication dates and source notes identify the material used for this edition; they do not guarantee that a rule remains unchanged when the book is read. Use the operative document for a decision involving a deadline, eligibility condition or financial consequence.

SAS Doctors Review at sasdoctors.com provides the associated professional website and a route to its contact and corrections information. The periodically refreshed public copy at sasdoctors.co.uk supports continuity of access. Readers should verify time-sensitive provisions with the original source organisation even when consulting an online companion.

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The parts follow the main decisions of an SAS career. Readers consulting a single chapter should retain the distinctions between grade, contract, nation and professional purpose established in Part One. For an immediate employment question, begin with the applicable documents. For a professional assurance question, identify the process and decision-maker. Use the source notes to return to the authoritative material before acting on a time-sensitive provision.

# Preface

I have spent much of my professional life in SAS practice. My work as a clinician, appraiser, educational supervisor and clinical director has also brought me into conversations about the conditions that allow doctors to practise well. Those conversations often begin with a practical question. Where should this duty appear in the job plan? What evidence would demonstrate the level of work? Which route applies to a doctor seeking a Specialist post? Why does a portfolio that satisfied one purpose seem insufficient for another? The difficulty is rarely a complete absence of information. More often, the information belongs to several systems that do not explain how they fit together.

An experienced doctor may understand the clinical service thoroughly while having had little opportunity to examine the employment arrangements supporting it. A newly appointed colleague may know the stated requirements of the post but discover that its everyday expectations are less explicit. Both need an account that connects documents with practice. They also need to know which questions cannot be answered by a colleague's recollection, a familiar title or an apparently similar case in another part of the UK.

This handbook grew from the material developed for SAS Doctors Review. The website brings together professional guidance, learning programmes, practical resources and links to authoritative organisations. Its breadth is useful when a reader needs to find a subject quickly. A book offers something different: space to examine a decision at length, explain why a distinction matters and follow the consequences into the next chapter. I wanted that space particularly for job planning, professional assurance, progression and pensions, where a short answer can conceal the very condition that determines whether it applies.

The handbook is a separate work from Surviving and Thriving in the NHS. That book addresses the wider experience of entering and understanding the NHS and building a professional life within it. Here, the starting point is the SAS career itself. The reader may be considering an SAS appointment, already established in autonomous practice or planning a change after many years of service. The emphasis is on the structures of that career and the decisions that make it workable. Broader accounts of adaptation to the NHS would add length without supplying the detail these decisions require.

I have also kept the treatment distinct from SAS Leadership in Practice. Leadership appears here because teaching, governance and organisational responsibilities affect an SAS doctor's work, evidence and future choices.

The handbook examines how those responsibilities are recognised, supported and recorded. It does not attempt to repeat the fuller study of leadership. Readers should be able to use this volume on its own, while finding clear reasons to consult a more specialised treatment when their question extends beyond it.

My experience informs the questions and the practical judgement offered in these pages. It does not establish a national contractual rule or settle another doctor's circumstances. For those matters, the book returns to the appropriate source: the relevant contractual documents, professional regulator, national policy owner or pension administrator. This matters particularly in a four-nation handbook. A useful practice in one organisation can be worth discussing elsewhere without becoming a right that every employer must implement in the same way.

I have written for doctors who want both explanation and something they can use. The chapters therefore move beyond describing a system. They show how to compare an offer, record work that has become invisible, prepare a job-planning meeting, select evidence, frame a development objective or seek advice with a clear question. These exercises are preparation aids. Their value lies in improving the conversation and its evidence, not in creating another collection of forms that the reader feels obliged to complete.

The composite doctors recur where their situations help connect the subjects. Their experiences are deliberately ordinary: responsibilities grow, information is missing, opportunities are delayed, and decisions have to be made before every uncertainty has disappeared. They do not always receive the outcome they hoped for. A useful example should explain what can be established and what remains for judgement. It should also show how an unresolved question can be carried forward without turning an assumption into an agreed fact.

Readers will sometimes find that a careful comparison exposes a problem they had not intended to examine. A proposed role may need a clearer escalation arrangement; a promising development objective may depend on time nobody has agreed to provide. Discovering that early is useful. It allows the discussion to address the conditions for success before disappointment is interpreted as an individual failure.

The book recognises the frustration that can accompany work which is necessary but poorly recognised. It also asks the reader to be precise. A request to correct the recorded workload differs from a request to create a senior post. An appraisal conversation differs from a pay-progression decision. Evidence of capability differs from a claim based only on years of

service. Careful distinctions can make a legitimate request more persuasive and help identify where the organisation needs to answer a different question from the one it has chosen to address.

I hope the handbook will also be useful to clinical managers, medical workforce teams, appraisers, supervisors and SAS advocates. They often hold part of the information required to make an arrangement work. Reading across those boundaries can reveal an avoidable gap: an objective without access to data, a responsibility without time, or a development plan without the experience needed to complete it. A well-prepared doctor and a well-prepared organisation have a better chance of resolving the same practical problem.

An SAS career can be a substantial professional life in its own right. Its quality should not depend on accepting a single destination or becoming indispensable through work that remains unrecorded. The aim here is to help readers understand their position, choose their direction and make the necessary arrangements visible enough to review. That is a continuing task. The book provides a way to undertake it with greater clarity and a more reliable account of the evidence.

# Introduction

## When the records describe different jobs

At the end of a busy month, a doctor prepares for two meetings. The first is a job-plan review. The second is an appraisal. The diary shows clinical sessions, messages answered between them, a teaching commitment and several discussions about a service problem. The job plan records the sessions but says little about the work between them. The appraisal folder contains course certificates and a brief account of teaching. A local directory gives the doctor a senior-sounding title that appears nowhere in the appointment letter. Each record contains something true. Taken together, they still fail to describe the job clearly.

It would be easy to respond by collecting more documents. That may help, but only after deciding what they need to demonstrate. A manager considering the timetable needs an account of duties, time and service requirements. An appraiser needs proportionate information about the whole professional practice and what has been learned. A recruiting panel needs evidence relevant to a particular role. The same teaching programme might contribute to all three accounts, but its existence does not answer every question each decision-maker has to consider.

This is the practical problem around which the handbook is organised. SAS doctors work within overlapping arrangements, each with its own purpose, language and evidence. A sound answer from one arrangement can become misleading when applied to another. The remedy begins with identifying the decision. What needs to happen? Who can decide it? Which source governs it? What information would allow that person or body to reach a defensible conclusion? These questions reduce the risk of preparing an impressive submission that answers the wrong test.

## The information is distributed

No single document can describe an entire professional career. The contract cannot anticipate every development in a service. The job plan cannot determine every requirement of a future application. An appraisal summary cannot replace the primary evidence needed to demonstrate a particular capability. This division has legitimate purposes, but it leaves the individual doctor with work to do at the boundaries. The handbook makes those boundaries explicit and shows how to carry information across them accurately.

Some information is national. Some applies to a particular contractual framework. Some belongs to the employer's implementation arrangements. Other information concerns the individual doctor's work and choices. A sentence beginning with 'the NHS requires' may hide all of these possibilities. Before relying on it, identify the issuing body, the relevant nation and the kind of requirement being described. A professional recommendation can be valuable without being a contractual term. A contractual entitlement can exist even when local practice has not implemented it well.

The same care is needed when comparing careers. Two doctors who share a grade can have different scopes of practice, opportunities, working patterns and contractual histories. The experience of one can suggest useful questions for the other. It cannot, by itself, establish the answer. Comparison works best when the assumptions are visible: which employment, which duties, which terms, which period and which decision? Without those details, a confident comparison can produce either an unrealistic expectation or an unnecessary sense of disadvantage.

The sources cited in this book are intended to make that enquiry easier. They identify the organisations and documents supporting the factual explanation. The practical reasoning then helps the reader apply a method to their own information. Where a detail is likely to change, the chapter explains what must be checked and why. A book cannot remove the need to consult an operative policy before submitting an application, but it can explain what to look for and how to recognise a material difference.

## Start with a question that can be answered

Consider the difference between asking for recognition and asking for a review of six hours of recurring work absent from the job plan. Recognition may be the underlying concern in both cases. The second request gives the recipient something specific to examine. It invites agreement about the work, its classification, the time needed and the available options. If those facts also support a discussion about a different role, that discussion can follow with its own criteria and decision-maker.

A useful question states the discrepancy without deciding the conclusion prematurely. 'My records show this duty on three sites, while the agreed plan names one; how should the requirement be represented?' leaves room to correct the record and examine the service. 'This proves I must be promoted' jumps across several decisions that the evidence may not establish. Precision does not mean abandoning ambition. It means protecting the argument from a claim that is broader than the available facts.

The same method applies to a development problem. 'I need more support' may be entirely justified but hard to operationalise. A request for supervised exposure to a defined activity, with agreed time and feedback against a specified capability, is easier to assess. The employer may still face a resource constraint. That constraint can then be recorded and reviewed, rather than appearing later as an unexplained failure by the doctor to achieve an objective.

Sometimes the answerable question concerns the process itself. Who makes the decision? Which policy version applies? Is the correspondence a request for information, an informal discussion or a formal notice? Has a deadline begun? These questions can be more urgent than the substantive argument. The chapters dealing with disagreement and concerns encourage early advice when an adverse consequence is possible. Good preparation should help obtain that advice; it should never become a reason to postpone it until the documents feel perfect.

## Build evidence that fits its purpose

Evidence begins with the claim it is intended to support. A timetable may demonstrate what was planned. A representative diary may demonstrate what happened during the sampled period. A report may show an improvement, but additional information may be needed to establish the doctor's contribution. A letter of thanks records appreciation; it does not necessarily demonstrate the whole capability described in a person specification. These distinctions help readers select material without dismissing useful evidence simply because it serves a limited purpose.

The strongest account is often smaller than the original folder. It identifies the question, selects relevant records, explains their dates and limits, and states what follows from them. A workload proposal, for example, should make its assumptions visible. The reader should be able to distinguish a representative average from a particularly difficult week and identify whether overlapping activities have been counted twice. A fair account can be persuasive precisely because it acknowledges what the data cannot establish.

Evidence also has a history. A proposal, an agreed plan, a completed activity and an evaluated result are different stages. Keeping those stages distinguishable avoids the common problem of reporting an intention as an achievement. It also makes incomplete work easier to discuss. If a project has not reached evaluation because access to data was delayed, the record should show the work completed, the unresolved dependency and the next

decision. It should not manufacture a result to make the portfolio appear finished.

The practical tools in later chapters support this discipline. They include document comparisons, workload records, objective builders and evidence indexes. Their formats are deliberately adaptable. The reader's organisation may already have a prescribed form or platform. In that case, use the handbook's questions to prepare the information and enter it into the required system. A useful method does not depend on persuading an employer to adopt the book's layout.

Return to the doctor preparing for the two meetings. The teaching folder contains slides, attendance figures and favourable comments. For the job-plan discussion, the relevant account includes preparation, delivery, assessment and follow-up time, together with who authorised the programme. For appraisal, the doctor may select the feedback that prompted a change in teaching and explain what was learned. For a later appointment, the same material may need to demonstrate the design of an educational programme, the doctor's personal contribution and how its effectiveness was evaluated. These accounts share a source, but each asks the evidence to do different work. Keeping a single secure index makes reuse easier; writing a separate explanation for each purpose preserves accuracy. The index should point to the approved location of sensitive material instead of reproducing it indiscriminately. The doctor can then identify missing evidence while it is still possible to obtain appropriate evaluation or confirmation, rather than discovering the gap shortly before an application closes. This is a practical saving in effort, not an argument for retaining every document that passes through a career.

## Choose the action and identify its owner

Once the evidence is organised, the next step should be stated plainly. A request may seek clarification, correction, agreement, opportunity, review or a formal decision. These are different actions. An email that asks for all of them at once can leave the recipient unsure which response would resolve the issue. It is often more effective to separate the immediate decision from the longer-term ambition and specify what needs to happen next.

Ownership matters because the person discussing the problem may not hold the authority to solve it. A clinical colleague can describe service needs but may not approve a contractual variation. An educational supervisor can identify a learning opportunity but may need another manager to release time. An appraiser can discuss a development objective while the employer must decide whether the required activity can be provided. The handbook

encourages readers to record these dependencies so that an apparently agreed objective does not become an unsupported personal obligation.

An action also needs a point of review. This is different from attaching an arbitrary deadline to every ambition. A review date creates an opportunity to examine what has changed, whether the information is now available and whether the proposed course remains sensible. If a decision cannot yet be made, the record should say what would allow it to proceed. Waiting becomes less opaque when the unresolved step and its owner are known.

Where disagreement persists, the appropriate route depends on the decision being challenged. The book does not treat every problem as a grievance or every delay as evidence of bad faith. It does explain why informal discussion should not be allowed to obscure a formal deadline. A proportionate approach can preserve the working relationship while retaining the documents needed for advice or review. Courtesy and a clear record are compatible with a firm request for an answer.

After an apparent agreement, check whether implementation actually follows. If a revised timetable releases time for governance, which clinical commitment has changed and who has arranged the cover? If a supervisor agrees to support development, when will the activity occur and how will feedback be obtained? If the meeting identifies a record error, who will correct the authoritative version? These questions prevent a favourable conversation from being mistaken for a completed change. They also provide a fair basis for follow-up: the doctor can refer to a specific agreed step rather than restating the original complaint. When an agreed action proves impractical, revisit its assumptions openly. A revised plan may be sensible, but the record should show what changed and why. Otherwise, the next review may treat an abandoned arrangement as something the doctor simply failed to complete. This habit makes progress intelligible to a successor manager as well as to the original participants.

## Read the career in connected parts

Part One establishes the vocabulary. It explains the range of SAS careers and separates grade, contract, role, scope, authority and registration. The four-nation chapter shows why the location of an employment matters even when professional regulation is shared. These are working distinctions. Readers will use them repeatedly when a familiar word appears to carry a different meaning in another document or conversation.

Part Two turns to entering or changing a post and understanding the employment framework. It asks what should be known before an offer is accepted and how the early months can establish reliable working

arrangements. The document chapter then explains how to examine national terms, individual agreements and local policies when their answers appear inconsistent. A reader already in post can use these chapters retrospectively to identify gaps in the current record.

Part Three examines how employment works in practice. Job planning receives detailed treatment because it connects duties with time, objectives and resources. The next chapter shows how to record work that does not appear in the visible timetable. Pay progression and additional work require related evidence but have their own contractual questions. The safety chapter then addresses what must happen when the work required exceeds the role, competence or resources available. An urgent clinical response cannot wait for a later employment meeting.

Part Four follows professional assurance through appraisal, revalidation and the portfolio before considering feedback and formal concerns. The sequence matters. A doctor needs to understand the purpose of each process and the information it uses. The portfolio chapter brings evidence together without pretending that one accepted submission automatically satisfies every other standard. The later concerns chapter addresses circumstances in which ordinary professional learning overlaps with an employer, legal or regulatory process.

Part Five examines progression. It begins with choosing a destination and then treats the routes separately: the relevant regrading arrangements in Wales and Scotland, competitive Specialist appointments in England and Northern Ireland, and specialist registration through the Portfolio Pathway. The evidence methods developed earlier are used again, but the applicable criteria remain specific to the route. A reader can pursue more than one destination while keeping the decisions and requirements distinct.

Part Six addresses sustained contribution and later choices. Leadership and education require time, authority and evidence as well as interest. Workplace dignity and support affect whether practice remains sustainable. The pension chapter explains mechanisms that are easily misunderstood and helps readers prepare for individual advice. Career transitions then bring professional responsibilities, personal circumstances and organisational continuity into the same planning conversation. The book's sequence follows these connections while allowing readers to enter at the chapter they need now.

## Use uncertainty without surrendering the decision

Some readers may hope for a handbook that supplies a definitive answer to every career question. That would require ignoring differences that matter.

The more useful aim is to make uncertainty specific. An unknown contractual term can be retrieved. An unclear role can be described. Missing evidence can become a development request. A disputed interpretation may need representation. Each is a different kind of uncertainty and calls for a different response.

There will also be choices for which several courses are reasonable. A doctor may value a narrower clinical role, an academic opportunity, geographical stability or reduced intensity more than a particular appointment. The handbook does not rank those preferences. It helps the reader identify the conditions and consequences of a choice, including the work needed to keep future options open. A career decision can be well made even when it differs from a colleague's recommendation.

Begin, therefore, with one issue that would benefit from clearer evidence. Describe the present position, identify the source that governs the question and decide what information is missing. Then prepare the next conversation. The chapters that follow supply the detail needed to make that process useful across an SAS career. The first improvement may be modest: an accurate document, a better question or an agreed review. Those changes provide a firmer basis for the decisions that follow.

# How to use the book

This handbook can be read in sequence or used to prepare for a particular decision. If you are unfamiliar with the distinctions between grade, role and registration, begin with Chapters 1 to 3. If the immediate question concerns an offer, read Chapters 4 and 5 before moving to job planning. For an established post whose workload has changed, Chapters 6 and 7 provide the main preparation method. Chapter 8 addresses the related contractual questions about progression and additional work.

For appraisal, start with Chapter 10 and use Chapter 12 to organise the evidence. Read Chapter 11 when confirming the revalidation connection, understanding the recommendation process or planning around a change of employment or a break. If a formal concern or adverse notice has arrived, identify the process and obtain timely advice; do not wait to complete a general reading programme. Chapter 13 provides the fuller account of feedback and formal processes.

Readers planning progression should first define the destination. Chapter 14 helps with that decision. The following chapters separate the national regrading routes, competitive appointments and specialist registration. The same portfolio may contribute to more than one route, but each submission must meet its own requirements. For a change in working intensity or retirement plans, read the pension and transition chapters together. Professional, employment and financial decisions may need to be sequenced rather than made independently.

At the start of a chapter, identify the question you want it to help answer. Keep a short note beside the text: my nation, my grade, my contract, my role and my intended decision. Add the relevant document dates when you know them. This small reference note helps prevent a worked example from being mistaken for a description of your own arrangements. Where the text names a specific nation or contract, retain that qualification when discussing the passage with colleagues.

Source notes support the factual explanations. Follow the original source when a provision determines eligibility, an entitlement, a formal procedure or a deadline. A source title alone is not sufficient if a later version has replaced the document. Look for the issue date, effective date, amendments and relevant schedule. When a website offers several historical documents, choose the one governing the particular employment or application rather than assuming the most recently uploaded file applies to everyone.

The cases explain decisions through illustrative people and settings. They are not reports of identifiable colleagues or precedents for a successful outcome. Ask what evidence changes the analysis and what further

information would be needed in your circumstances. Where the case provides numbers, retain its stated assumptions. A diary example may illustrate measurement without establishing a contractual allocation; a financial example may explain a mechanism without recommending a personal choice.

Use the practical tools selectively. A document map is useful when records disagree. A workload diary is useful when the timetable omits recurring activity. An evidence index is useful when material is difficult to retrieve. None requires you to create a parallel bureaucracy for every part of your working life. Start with the smallest record capable of answering the question, keep it in an appropriate system and review whether maintaining it remains worthwhile.

Keep your reading notes separate from the authoritative record. A margin note can capture a question or possible interpretation, but it should not be copied into a submission as though it were the policy itself. When preparing a formal account, return to the source and distinguish quotation, paraphrase and your own proposal. This helps an adviser test the reasoning without first untangling where each statement originated or what status you intended it to have.

For a professional meeting, translate the chapter into a short preparation note. State the issue, identify the relevant source, summarise the evidence and propose the next action. Bring the supporting documents, but do not make the recipient reconstruct the question from a large attachment bundle. After the meeting, record what was agreed, what remains unresolved, who will obtain missing information and when the position will be reviewed. Distinguish a proposal from an authorised change.

Confidentiality applies to preparation as well as formal submission. Avoid copying patient records, identifiable correspondence or sensitive employment material into personal notes or online tools simply because they might be useful later. Use approved arrangements and seek advice about anonymisation, retention and transfer. A portfolio should preserve a defensible account of your contribution without becoming an unauthorised archive of other people's information. Chapter 12 examines these questions in more detail.

SAS Doctors Review provides related online learning and resources. The printed explanations are intended to remain useful without an account or a particular browser feature. When using an online worksheet, understand whether information remains only in the open page, is downloaded to your device or is stored elsewhere. Do not assume a tool is an approved place for

confidential information because it appears on a professional website. Use your organisation's required system for the actual submission.

Finally, use the advice boundaries as practical signposts. A pension administrator can explain scheme records and procedures; personal tax or retirement choices may need a different adviser. A clinical manager may resolve an operational question; a contractual dispute may require employment representation. A defence organisation may need to advise on a professional concern before a substantive response is sent. Arrive with the relevant documents and a clear chronology, while allowing the adviser to identify issues you have not recognised.

# Terminology note

SAS is used here as a collective description of Specialty Doctors, Specialists and Associate Specialists, with relevant historical grades acknowledged where they affect an individual's position. It is not a substitute for the exact grade and terms in an employment agreement. A statement about one national SAS contract should not be assumed to apply to every doctor described informally as SAS.

Specialty Doctor refers to the employment grade. Specialist, with a capital initial where the distinction matters, refers to the Specialist employment grade. Specialist registration means entry on the GMC Specialist Register. These descriptions answer different questions. A reader should identify whether a document concerns appointment to a post, the scope of work in that post or registration, rather than relying on the word specialist alone.[1,2]

Associate Specialist refers to the employment grade held by doctors under the relevant arrangements. Historical or locally used titles should be read with the accompanying contract. The book does not infer a doctor's entire scope, level of autonomy or organisational powers from a title. Those features require their own account of work, competence, appointment and delegated authority.

LED means locally employed doctor. The term describes an employment grouping, not a single national contract or level of capability. A clinical fellow or similarly titled post may have local terms even when some duties resemble those of a national SAS post. Doctors moving between these arrangements should compare the documents and requirements explicitly. Similar pay or a shared rota does not establish identical terms.

Appraisal denotes the professional review described in the relevant chapter. Revalidation denotes the GMC process concerning continued licensed practice. The appraiser, responsible officer or suitable person, employer and GMC have different functions. A professional portfolio is the organised evidence supporting one or more defined purposes. Acceptance of information for one purpose does not automatically establish its adequacy for another.

Portfolio Pathway is the term used for the GMC route discussed in Chapter 18. Older material may use CESR or related historical terminology. Readers should use the current application route and specialty guidance when preparing evidence. A career-development portfolio is not itself a Portfolio Pathway application, even when some of its material may later support one.[8]

England, Wales, Scotland and Northern Ireland identify the relevant national context. UK-wide is used only where the statement is intended to apply across the UK. NHS is sometimes used collectively for readability; where a contractual or administrative distinction matters, the text names the relevant system, including Health and Social Care in Northern Ireland. PA means programmed activity where that term is used by the applicable contract. Session is retained where it is the contractual unit. Numerical examples explain their own assumptions rather than treating the terms as universally interchangeable.

Must, should and may have different force. In a sourced rule, preserve the source's meaning. In practical guidance, the book explains a recommended method or reasonable option. An illustrative suggestion should not be converted into an entitlement or mandatory requirement merely because it appears in a checklist.

Chapter 1

# The SAS career in the modern NHS

## The problem of the missing map

Daniel's job description still described the service he had joined eight years earlier. It named one hospital, a set of clinics and a supporting role in the department. His working week now included a second site, independent decisions about complex patients, advice to colleagues between clinics, supervision of a newer doctor and responsibility for a recurring governance meeting. None of these changes had arrived as a single new appointment. Each had seemed reasonable when someone first asked. Together, they had created a different job.

At his annual review, Daniel said that he wanted his seniority recognised. His manager asked what recognition would mean. More pay, a different title, fewer clinics, a leadership appointment, or a route to the Specialist grade? Daniel had prepared a list of what he did, but he had not separated these questions. He left the meeting frustrated, believing that the work should speak for itself. His manager left uncertain about what decision was being requested. Both could describe the service pressure. Neither had a sufficiently clear account of the employment problem.

Daniel is a composite doctor, not a report of an individual dispute. His difficulty illustrates the starting point for this handbook. A professional career can change considerably while its documents remain almost still. Familiarity makes the mismatch less visible: colleagues know whom to call, patients receive care, and the rota continues. The doctor may become essential to a system that cannot adequately describe either the contribution or the conditions required to sustain it. Recognition then becomes an emotionally important but administratively imprecise request.

The first useful step is to ask which question needs an answer. If the recorded timetable omits necessary work, the immediate issue is job planning. If the employer requires a formally established senior role, there may be a workforce and appointment question. If Daniel wants specialist registration, he needs a regulatory route and the appropriate evidence. If he wants time for teaching, he needs to establish the duties, their purpose and the resources required. Evidence may support several of these conversations, but one process will not decide them all.

A better second meeting would therefore begin with a specific discrepancy. Daniel could show the original job description, the latest agreed job plan and a proportionate account of the work now required. He could ask the manager to agree what the service expects, identify which commitments already have authority, and arrange a review of the time and support. Alongside that, he could ask who considers the establishment of Specialist posts and what evidence that separate discussion requires. The outcome is uncertain, but the requests are now capable of being answered.

This book follows that movement from an experienced problem to a question that can be investigated. It starts with the relevant rule or agreement, tests the evidence against it, and helps the reader prepare the next action. It also identifies the point at which individual representation or professional advice becomes necessary. This is a practical discipline for doctors whose work crosses several organisational systems. It does not make those systems simple, and it cannot guarantee a favourable decision. It makes it harder for a legitimate question to disappear because nobody has defined it.

Daniel also needs to distinguish a correction from a proposal. Asking that an agreed duty be recorded accurately is different from asking the employer to create a new responsibility. Both may be reasonable requests, but they depend on different evidence. Putting them in separate paragraphs helps the manager respond to each without accepting or rejecting the whole account as a single package. It also shows Daniel where further advice would be useful.

## Who belongs within the SAS career

SAS is a collective workforce description covering Specialty Doctors, Specialists and Associate Specialists, with historical grades and terminology still relevant to individual careers. The exact contractual position must be established from the relevant nation's documents and the doctor's own employment record. Throughout this book, Specialist with an initial capital refers to the employment grade where the context requires that distinction. Specialist registration refers to entry on the GMC Specialist Register. The two are different, and much avoidable confusion follows from treating them as equivalent.[1,2]

The intended reader may be newly appointed to a Specialty Doctor post, experienced in a defined field, considering a senior appointment or planning the final working years of a long career. The same reader may need different chapters at different times. Someone preparing for a first job-planning meeting needs the basic document set and a realistic account of duties. A doctor seeking a Specialist post needs to demonstrate the relevant

capabilities against that post's requirements. An Associate Specialist considering reduced work needs an integrated employment, professional and pension plan.

Not every doctor outside a formal training programme is employed on national SAS terms. Locally employed doctors may have job titles such as clinical fellow or trust doctor and may perform work alongside SAS colleagues. Their contracts and routes into subsequent posts require separate examination. Working on the same rota, receiving similar pay or having comparable experience does not by itself establish the same employment terms. Chapter 2 explains how to make that comparison without using either group as a proxy for the other.

Doctors considering an SAS career are welcome readers too. Some will have trained overseas; some will have worked in UK training posts; others will be changing specialty, returning after a break or seeking a more sustainable pattern of practice. The relevant question is what the proposed role requires and whether the doctor has, or can develop, the necessary capability within a safe and properly supported appointment. Previous career labels can help explain experience, but they cannot replace an assessment of the work that is now proposed.

An SAS doctor can also be an educator, appraiser, researcher or organisational leader. These are functions and appointments that need their own evidence and arrangements. Holding a substantive clinical grade does not tell a reader which additional responsibilities have been agreed. A doctor's professional identity may reasonably include several roles, but the employment record should make each intelligible. Otherwise, duties that colleagues regard as established can depend on informal goodwill, and the doctor may be unable to explain what should continue when one appointment ends.

The handbook does not prescribe one desirable destination. A reader may wish to stay in the same grade and improve the quality of the job. Another may seek a Specialist appointment. Another may pursue the Portfolio Pathway to specialist registration, with or without changing employment immediately. Some will prefer to reduce out-of-hours commitments, develop teaching or move to a service that fits their expertise. These choices deserve different preparation. Treating all development as a journey towards consultancy prevents the reader from examining the actual options available.

It is equally important not to make an SAS identity so broad that contractual distinctions disappear. Inclusion in a professional community is different from entitlement under a particular agreement. A locally employed

doctor may benefit from the book's evidence methods while needing advice on a local contract. A dentist working under related arrangements may recognise many of the employment questions while requiring dental regulatory and professional sources. The clinical and regulatory discussion here is written for doctors. Similar terminology should prompt a check of applicability, not an assumption that every rule transfers.

The reader's position within the career may be mixed. Someone can hold a national SAS post for most of the week and a separately contracted role elsewhere. The second appointment does not automatically acquire the terms of the first. Keep each employment identifiable, then bring their professional activities together when considering the whole scope of practice. This is especially important when a question about hours or resources in one job is presented at an appraisal that also considers work undertaken for another organisation.

## Diversity without false uniformity

Two doctors can share a contractual grade and have markedly different working lives. One may deliver a defined outpatient service with predictable access to senior colleagues. Another may provide autonomous inpatient care across several sites. A third may combine clinical work with formal educational responsibilities. Their shared grade is relevant to employment, but it does not explain the clinical breadth, intensity, support or authority of each role. A useful account of the SAS workforce must leave room for these differences rather than replacing them with an average doctor who does not exist.

Specialty matters because it shapes the work that needs to be evidenced. A procedural service may make activity easy to count while leaving preparation, follow-up and governance less visible. Community work may involve travel and communication across organisational boundaries. Psychiatry may require a different account of multidisciplinary decision-making and legal responsibilities. Diagnostic practice has its own relationship between reporting, advice and quality assurance. These are illustrative differences, not a ranking of specialties. The later job-planning chapters begin with the work and its dependencies before attempting to convert it into time.

Seniority also has several meanings. Years since qualification, years in a specialty, years in an employing organisation and experience of a particular service can produce different strengths. Long service may bring a deep understanding of local pathways. Recent experience elsewhere may reveal an overlooked alternative. Neither automatically establishes capability for

every senior task. An application or role review should identify what the doctor can demonstrate, in what context, and with what degree of independence. Length of service is relevant background; it is not a complete description of practice.

Working patterns need similar care. A less-than-full-time doctor may retain a substantial leadership responsibility whose demands do not reduce neatly with clinical sessions. A doctor with several employers may need to assemble information across systems for appraisal. A colleague returning from leave may have extensive previous capability but need an agreed period of reorientation. A person undertaking predominantly non-resident on-call work may have demands that are poorly represented by a count of physical attendances. Good career planning allows these differences to alter the questions asked.

International experience should be described accurately and assessed on its merits. It should neither be treated as a deficit nor translated uncritically into UK organisational authority. A doctor may bring years of relevant independent practice while needing induction into unfamiliar referral routes, prescribing systems or escalation arrangements. Another may know the NHS well but require development in a new clinical domain. Those needs are different. Asking precisely what must be learned avoids the unhelpful choice between undervaluing experience and assuming that all experience transfers unchanged.

Workforce figures can illuminate these issues, but only when their definitions are clear. A headcount measures people; a full-time-equivalent figure measures contracted capacity according to the dataset's method. A combined SAS and locally employed category answers a different question from an SAS-only count. Figures from different years or nations may not be directly comparable. Before using a statistic in a business case, identify the population, date and unit. Do not turn a broad workforce trend into a claim about the capability, aspirations or circumstances of every doctor within it.

For an individual reader, the practical alternative to false uniformity is a short description of the actual job. State the clinical setting, regular duties, additional roles, working pattern, support and intended direction. Include the nation and contract. This description becomes a reference point throughout the book. When advice appears relevant, ask whether its assumptions match that description. The exercise takes less effort than repeatedly trying to resolve a disagreement caused by applying an accurate statement to the wrong kind of post.

Ask a colleague to read that description without filling gaps from personal knowledge. If they cannot identify which work is independently

undertaken or who provides support, the description needs revision. This small test is particularly useful before sending it to a prospective employer.

## A substantive career

A career needs to be understood on its own terms before its future can be planned. SAS practice can be a deliberate long-term choice, a route through changing professional interests or a position from which a doctor seeks another appointment. The same individual may move between these intentions over time. A decision made when children are young, when health changes or when a service offers an unusual opportunity need not define the next twenty years. Career planning should allow revision without treating every change of direction as evidence that the earlier choice was mistaken.

The phrase career progression can conceal several distinct ambitions. The doctor may want a broader clinical scope, formal recognition for an existing level of work, higher remuneration, greater control over the timetable or a chance to contribute to education. Some ambitions overlap; some compete for time. A new leadership appointment may increase influence while reducing the clinical exposure needed for another goal. A change in working pattern may improve sustainability but require a longer timetable for collecting particular evidence. The useful task is to identify these relationships before committing to a route.

Consider Aisha, newly appointed to a Specialty Doctor role after several years of clinical work elsewhere. Colleagues offer well-meant but conflicting advice. One recommends entering training immediately. Another says she should aim for specialist registration. A third suggests waiting until she has spent longer in the department. None has yet asked what she wants her working life to contain. Aisha's first task is therefore to identify a provisional destination, the experience she already has and the opportunities she needs. A short development plan can then test a direction without demanding a permanent commitment.

For Daniel, the question is different. He already delivers a substantial service and wants the formal arrangements to reflect it. He may need a job-plan correction whether or not a Specialist appointment becomes available. If he combines those issues, the employer might treat all discussion as dependent on a future vacancy. Separating them preserves the immediate question about current work. It also helps Daniel decide whether he wants a changed post, a better description of the existing one, or both. A practical career plan contains decisions at different timescales.

Remaining in a grade should not mean remaining professionally static. A doctor can improve clinical judgement, teach more effectively, contribute to

safer systems or develop research skills without seeking another title. The work should still have suitable support and evidence. Equally, an organisation should not use a doctor's satisfaction with clinical work as a reason to leave longstanding mismatches unexamined. Personal contentment and accurate employment arrangements are separate matters. The reader can value an existing career while asking for a better account of the conditions under which it is practised.

There is also a risk in allowing a single application to become the measure of an entire career. An unsuccessful recruitment process may reflect the demands of that vacancy, the evidence presented, the strength of other candidates or circumstances that need further explanation. It does not provide a comprehensive judgement of the doctor's professional value. The constructive response is to obtain feedback, distinguish remediable evidence gaps from a mismatch of destination, and decide what to do next. Later chapters examine these steps in detail, including when a process itself needs to be questioned.

A substantive career therefore requires more than endurance. It needs periodic choices about the work worth continuing, the capabilities worth developing and the arrangements that make both possible. Some choices will be constrained by service needs, resources or personal circumstances. Naming those constraints is useful because it prevents a development plan from becoming a list of obligations placed entirely on the doctor. Progress may require an employer to provide experience, a supervisor to assess it or a service to redesign a role. The plan should say so explicitly.

It can help to give an ambition a review date rather than a deadline for success. At that review, ask what has been learned about the proposed destination and whether it still fits. A change of plan can be an informed outcome of good preparation. It need not be disguised as a temporary delay in a journey the doctor no longer wishes to make.

## Responsibility recognition and authority

Professional responsibility is not suspended because a job description is poor. A doctor still needs to practise within competence, take appropriate action for patients and seek help when required. Good medical practice supplies the professional standards against which doctors should consider their conduct.[3] That does not mean a doctor personally controls every condition affecting care. A service may depend on staffing, diagnostics, transport, specialist advice and other resources controlled elsewhere. Describing those dependencies is essential to understanding what an individual can reasonably decide and what needs organisational action.

Clinical autonomy should be defined by the work. A doctor may independently assess and manage a particular patient group while referring problems outside that scope. Appropriate referral is part of competent practice, not evidence that autonomy was illusory. Similarly, a doctor with a senior title may seek advice on a difficult or unfamiliar problem. The useful distinction concerns the decisions the doctor is equipped and authorised to make, the circumstances requiring additional input, and whether that input is actually available. An undefined claim of independence does little to make care safer.

Organisational authority concerns a different set of powers. Someone may be asked to improve a service without authority over its budget, staffing or operational policies. They may chair a meeting without being able to approve its recommendations. These arrangements can be workable when the limits and escalation routes are explicit. They become problematic when responsibility is described broadly but the power to act remains elsewhere. Before accepting a role, the doctor should understand which decisions belong to it and which must be taken to another person or body.

Recognition matters partly because it makes these arrangements visible. An accurate title can help colleagues identify the person responsible for a function. A revised job plan can show the time committed to it. An appointment letter can establish reporting and review. These documents serve different purposes, and recognition may require more than one of them. The aim is not to accumulate impressive labels. It is to create an account of the work that remains understandable when a manager changes, a colleague leaves or the role must be handed over.

In Daniel's case, being regarded as the experienced person in the service does not tell him whether he can change a pathway or commit another team's resources. If colleagues routinely ask him to resolve staffing gaps, he needs to know whether this is advice, a delegated management duty or a responsibility that belongs elsewhere. The answer affects both the job plan and the response when a request cannot be fulfilled. A clear boundary can protect patients by ensuring that unresolved decisions reach someone who has the authority to make them.

Doctors should also distinguish recognition from exemption. Experience does not remove the need for appraisal, relevant training, appropriate oversight or honest examination of a concern. Conversely, legitimate oversight should not be designed around an inaccurate assumption that all SAS doctors need the same degree of clinical supervision. The question is what the role and individual practice require. A proportionate arrangement can recognise advanced capability while keeping opportunities for advice

and review. Trust is strengthened when expectations are explicit enough to be tested rather than dependent on personal familiarity.

When responsibility exceeds available resources, two conversations may be necessary. The immediate conversation concerns safe care and the action required now. The subsequent conversation concerns whether the service and job plan remain workable. Keeping those conversations distinct avoids trying to settle an employment disagreement during an urgent clinical event. It also prevents repeated temporary solutions from becoming invisible. Chapter 9 examines how to document the pattern, identify the decision-maker and pursue a proportionate response without turning every operational difficulty into an individual confrontation.

A role should remain understandable in the doctor's absence. If colleagues cannot identify the substitute decision-maker or escalation route, the organisation has a continuity question to resolve alongside the individual job-plan discussion.

## How decisions accumulate across a career

A job plan, appraisal record and professional portfolio often sit in different systems. The work that generates them is largely the same. A teaching responsibility takes time in the job plan, produces material for appraisal and may contribute evidence to a future application. If the responsibility is recorded differently in each place, the doctor repeatedly reconstructs it. A coherent account makes the connection without pretending that the processes have identical requirements. The same activity may be relevant to several purposes, but the explanation and supporting evidence must fit each purpose.

Small agreements can have long consequences. Covering a meeting once may become a standing expectation. A temporary clinic may continue after the original reason has passed. An additional role may retain its objectives after the allocated time disappears. The doctor and manager may both remember the original arrangement differently. For this reason, a brief record of what was agreed, for how long and subject to what review is often more useful than a lengthy later account of why the situation became unsustainable. The record creates a shared reference while the facts are still clear.

Evidence also has a timing problem. A doctor planning an application may discover that useful records were held by an employer they have left, that a supervisor has retired or that an improvement project's original data cannot be accessed appropriately. This does not justify indiscriminate copying of clinical material. It supports planning ahead for lawful,

proportionate retention of evidence and verification. Chapter 12 sets out a method for identifying the source, the purpose of the evidence and the arrangements needed to use it securely.

Appraisal can help identify these connections, but it cannot make every related decision. A development objective may require a manager to agree protected time, a department to provide experience or another organisation to confirm eligibility. The appraisal conversation can clarify the need and record a plan. It does not itself create the employment agreement. A useful personal development plan therefore separates what the doctor will do from what somebody else needs to approve. Otherwise, an objective may appear to be progressing while its essential dependency has never been addressed.

Later-career decisions introduce another set of connections. Reducing work may affect service cover, leadership succession, appraisal information and pension arrangements. Those consequences should be considered before a date is fixed. Pension administration and tax are complex enough to need their own detailed treatment in Chapter 21. At this stage, the important point is procedural: obtain the relevant records and advice early enough to compare choices. A decision about a working pattern should not depend solely on an estimate remembered from a colleague's quite different circumstances.

The career map should therefore be reviewed at transitions, not filed away after induction. A change of employer, specialty, working pattern or additional role is an opportunity to check whether the records still describe reality. Review is also worthwhile when nothing outwardly has changed but the workload has gradually altered. Daniel's problem developed through accumulation rather than a formal announcement. A periodic comparison of expected and actual work would have made the mismatch visible earlier, when the questions were smaller and the evidence easier to assemble.

Record closed decisions as well as open ones. If an additional duty ends, note the date, the handover and the resulting change to the timetable. Otherwise, an old objective may reappear in the next review simply because it remains on a template. Accurate removal of work is as important as accurate addition. It helps the doctor and employer distinguish an unmet commitment from one that was properly discontinued by agreement.

## How to use this handbook

The opening chapters establish the distinctions that later practical chapters use. Chapter 2 separates grade, contract, title, scope and registration. Chapter 3 locates these questions within the four UK nations. Readers who begin with job planning, progression or pensions should return to those

distinctions whenever advice appears inconsistent. Often, two apparently contradictory statements concern different contracts or different decisions. Establishing the context can resolve the contradiction before the reader invests effort in a detailed argument about a rule that does not apply.

The middle of the book deals with the employment relationship and professional assurance. Job planning is given substantial space because it connects duties, time, objectives and resources. The appraisal and revalidation chapters then explain how evidence of professional practice is gathered and used. The progression chapters distinguish the Wales and Scotland regrading routes, competitive Specialist appointments and the Portfolio Pathway. These are separate routes with different decision-makers. The final part addresses contribution, support and sustainability, including pensions and later practice. Cross-references connect related decisions without requiring the reader to treat them as one process.

Read the cases as opportunities to test a decision, not as precedents that establish an entitlement. Names and circumstances are invented or combined to protect confidentiality. A case states enough information to explain the question while leaving room for legitimate uncertainty. Where a different contract, policy or clinical context would change the answer, that difference matters. The most useful response is often to ask which missing fact would determine the next step. This prepares the reader for real conversations, where information is rarely complete at the outset.

The practical tools are preparation aids. They do not replace an employer's required form, a GMC submission or a pension administrator's calculation. Use them to organise the information that the official process needs and to identify questions for advice. Keep confidential records within approved systems. A personal career document should not become an unsecured collection of patient information, colleague details or sensitive employment correspondence. Record what evidence exists, where it is held and how it may properly be accessed before deciding whether a copy is necessary.

Source notes identify the organisations and documents behind operative statements. Their dates matter particularly for pay, policy and pension questions. Consult the current source before acting on a time-sensitive provision. The accompanying website offers an additional place to look for material, but it does not replace the issuing organisation's current document or the terms that apply to an individual employment.

Begin with a one-page career position and priority decision map. Write the nation, employer, contractual grade and contract version at the top. Add the main clinical duties, additional roles and working pattern. Then identify

one current decision in a sentence: for example, agreeing time for necessary follow-up work, preparing for a particular vacancy or checking the consequences of a proposed reduction in work. Under that sentence, list the documents already available, the missing information, the person or body that can decide, and the next action with a realistic date.

If the map produces several problems, choose an order. An immediate safety concern cannot wait for a long-term career plan. A short process deadline may require early advice. A development ambition may need months of planned experience. The purpose of ordering is to avoid spending all available effort on the most emotionally prominent issue while a time-sensitive one is neglected. Revisit the map after the first conversation and record what changed. By the end of this chapter, the reader should have a defined question. The next task is to identify exactly which aspect of the professional role that question concerns.

Chapter 2

# Grade title contract role and scope

## Five labels that answer different questions

An appointment letter, hospital directory and clinical rota can describe the same doctor in different ways. That is not necessarily an error. Each document may be answering a different question. The difficulty begins when a label designed for one purpose is used to settle another. A rota describes deployment. A contract establishes employment terms. A register records regulatory status. None should be expected to provide a complete account of professional capability, and none becomes irrelevant simply because colleagues use a more familiar title in conversation.

Start with contractual grade. This identifies the employment category under which the doctor is appointed. Its practical significance depends on the relevant terms and conditions and any applicable amendments. Grade can affect the framework for pay, progression and job planning. It does not give a complete description of the patient groups seen or the decisions made. When someone says that a duty is or is not appropriate to a grade, ask which requirement, capability or contractual provision they mean. The label alone is too blunt to settle a detailed question about work.

The contract is the agreement governing the employment relationship. A national model may supply much of its content, but the individual appointment and incorporated documents still matter. Identify the employing entity, the stated grade, the relevant national or local terms and subsequent variations. A doctor may hold several contracts at once. A national SAS contract for one post does not automatically govern a separately appointed educational or external role. Keep the documents distinct even where a single employer administers the pay for both.

The job title is the description used to identify the post or function. It should be accurate and useful, but a locally chosen title may not establish national contractual status. A service might describe someone as its lead doctor, senior clinical fellow or specialist clinician. Before drawing conclusions, ask what the title means in that organisation and which document supports it. The answer may be a formal appointment, an agreed functional description or simply habitual usage. Those possibilities have different implications when the doctor applies elsewhere or asks for a change in terms.

Scope of practice describes the work the doctor actually undertakes and is equipped to undertake safely. It includes the context and limits of that work. A narrow but advanced procedural scope can differ substantially from broad acute practice, although both may involve independent decisions. Scope changes with training, experience, recency and the service environment. It therefore needs a more precise account than a job title can supply. When a new duty is proposed, compare it with the doctor's current practice and the support available before assuming that it falls within an existing label.

Register status answers a regulatory question. The GMC medical register records a doctor's registration and licensing position and, where applicable, specialist or GP registration. An employer's use of Specialist as a grade does not itself confer entry on the Specialist Register.[2] Conversely, the register does not tell a reader what contract the doctor currently holds. A person can have a regulatory qualification or status that is not reflected in the title of their present post. Understanding that distinction avoids using employment documents to prove something that only the register can establish.

In practice, five separate answers are more useful than an argument about which label is the real one. Write down the grade, the contractual source, the local job title, the defined work and the register position. Then state the decision under consideration. If the question concerns pay progression, the employment framework leads the inquiry. If it concerns a new procedure, capability and governance become central. If it concerns specialist registration, the GMC route controls. Several answers may be relevant, but their relevance must be explained rather than inferred from the most senior-sounding word.

Keep the date beside each answer. A record can accurately describe a previous appointment while being unsuitable evidence of the current position.

## Specialty Doctor Specialist and Associate Specialist

The modern SAS workforce includes doctors on different generations of national terms. England's published 2021 materials distinguish the reformed Specialty Doctor contract from the Specialist contract, and separate national documents must be used for the other UK nations.[1,4,5] Older arrangements remain relevant to doctors who continue to hold them. The date on which a colleague joined a service is not sufficient to identify the contract now in force; a transfer or later variation may have changed the position. Retrieve the individual record before making a comparison.

A Specialty Doctor post should be understood through its actual requirements and the relevant contractual framework. There is considerable

room for development within a career, and a doctor's work may become more complex over time. That growth needs to be recognised in the description of duties, support and evidence. It should not be used to assume that every person with the grade has the same scope. Nor should a narrow reading of the title prevent an employer from examining evidence of advanced practice. The proper discussion starts with what is required and demonstrated.

The Specialist grade concerns a senior employment role with an associated capability framework and the requirements of the particular post. Its significance should not be reduced to an additional pay point or an informal description of being experienced. A candidate needs to understand the role that the employer wishes to fill and the evidence against which suitability will be considered. The national framework provides a structure; the service context gives that structure practical meaning. Later chapters examine the different routes through which such appointments or regrading may be considered.[6]

Associate Specialist is a distinct grade with its own historical and contractual position. It should not be used as a casual label for every experienced SAS doctor. A closed grade can continue to matter greatly to people who hold it; closure to new entry does not erase their existing employment or contribution. Equally, another doctor does not acquire that grade merely by working alongside an Associate Specialist or undertaking similar duties. The relevant national and individual documents need to establish the position, particularly when a transfer or change of contract is being considered.

There is a temptation to arrange these descriptions as a universal clinical ladder. That can be misleading. Contractual structure and actual expertise are related, but they are not identical. A doctor may have exceptional knowledge in a defined field without holding the newest senior grade. A newly appointed senior doctor may need local induction and advice on unfamiliar systems. Recognising these facts does not make grades meaningless. It means that grade should be used for the question it answers, while capability and support are examined directly when clinical responsibility is being allocated.

Historical titles need careful translation. When preparing a curriculum vitae, retain the formal title used at the time and explain the relevant duties in plain language. Replacing an old title with a modern one may make the account look simpler while making it less accurate. If an appointment was local, say so. If national terms applied, identify them where relevant. A recruiter can then assess the experience without having to guess whether the

candidate is claiming an employment status or describing the level of work. Accuracy is more persuasive than an embellished equivalence.

Consider a department with a long-serving Associate Specialist and a more recently appointed Specialist. It would be unhelpful to decide their relative authority from those labels alone. Who holds a particular leadership appointment? What clinical decisions are each expected to make? What does the on-call arrangement require? Who has authority to approve a service change? Those questions may have different answers. A well-described service can respect both doctors' experience while identifying responsibility for each function. Ambiguity should be resolved through the role arrangements rather than through an informal contest over seniority.

For the individual, the practical check is straightforward. Compare the grade named in the appointment letter with the terms identified in the contract and the current payroll record. If they differ, ask for an explanation before assuming an error or an entitlement. Then compare the role described with the work expected. This produces two inquiries: whether employment administration accurately reflects the agreement, and whether the agreement adequately describes the service. Resolving the first does not automatically resolve the second, but keeping them separate makes both easier to investigate.

## Locally employed doctors and local contracts

Locally employed describes an employment arrangement, not a uniform level of clinical ability. A clinical fellow may be early in a UK career, experienced overseas, developing a particular skill or contributing at a senior level within a defined service. The title alone cannot establish which of those circumstances applies. Local contracts may use familiar medical language or pay references, but resemblance to national SAS arrangements does not by itself incorporate every national term. The reader needs to establish the actual agreement and any documents expressly made part of it.

This distinction is particularly important when comparing offers. Two adverts may describe similar clinical work while providing different arrangements for development, pay progression, leave or review. A salary figure cannot answer all those questions. Ask for the written terms and a clear account of how the role is supported. If the employer refers to a national payscale, clarify whether that reference concerns salary only or a wider contractual framework. The answer should come from the agreement or an authorised clarification, not an assumption based on the way colleagues describe the post.

The boundary between an LED role and an SAS appointment can also be blurred by the rota. A doctor may cover duties usually performed by a Specialty Doctor, while another may rotate through assignments shared with doctors in training. Deployment is relevant evidence about actual work. It does not, by itself, settle the legal or contractual classification of the employment. If the arrangement raises a concern, gather the advert, contract, rota and duties, then seek advice on the precise discrepancy. Avoid converting a reasonable observation about comparable work into an unsupported claim of automatic status.

Development promises deserve the same examination. A post described as a fellowship may offer structured supervision and useful experience, or the educational element may be less clearly defined. Before relying on it, identify the supervisor, the intended learning, the time available and how progress will be assessed. A general statement that opportunities exist is weaker than an arrangement naming the activity and its dependencies. A doctor's effort cannot compensate for a service that has no capacity to provide the promised experience. This is an employment-design question as well as a personal planning issue.

A doctor wishing to move into an SAS post should identify the route that currently applies. This may involve competitive recruitment or a specific published employment framework where one applies to the employer and circumstances. Announcements about eligibility, permanency or transfer should be read for their exact scope and dates. They must not be treated as a general promise of promotion to the Specialist grade. Where a framework is time-limited or recently introduced, use the current authoritative text and obtain individual advice before relying on a summary or another doctor's outcome.

For an employer, accurate classification matters because it determines what is being offered and expected. A local title should not obscure a service requirement for sustained autonomous practice or make the support arrangements difficult to identify. For the doctor, accurate language matters when presenting the role in an application. Describe what was done, who supervised or verified it, and the circumstances in which decisions were made. That evidence can be valuable without relabelling the post. A clear account lets the assessor judge the contribution rather than first having to untangle the terminology.

The handbook's practical methods therefore apply across a useful boundary. An LED reader can use a workload diary, evidence index or career decision map. They should not assume that a chapter's national SAS contractual provision applies to their local agreement. An SAS reader

supervising or working alongside an LED should make the same distinction. Shared professional respect is compatible with precise employment language. Indeed, precision often helps identify where a local arrangement needs improvement without making an inaccurate claim about a right or process that belongs to another contract.

Where an offer remains unclear, ask for clarification before relying on an assumed equivalence.

## Scope of practice and clinical autonomy

Scope should describe decisions, patients and circumstances, not simply list clinical settings. Saying that a doctor works in a ward or clinic leaves unanswered what they manage independently, which problems require consultation and what support is available. A useful description might identify the patient group, the common decisions, the limits of a procedural practice and the route for an unexpected presentation. It should be specific enough that another professional can understand the arrangement. Otherwise, the word autonomous may conceal different expectations among the doctor, manager and wider team.

Competence is also sensitive to context. A skill previously used regularly may require review after a prolonged gap. A procedure performed with established facilities and immediate support may create different risks in another setting. A doctor moving between services should identify these differences during induction rather than waiting for a difficult case. The purpose is to understand what can safely transfer, what needs orientation and what requires further development. This is a normal feature of professional practice, not a reason to discount prior expertise or treat every move as a complete restart.

Clinical autonomy and access to advice should support each other. A doctor can take independent responsibility within a defined scope while knowing when and how to obtain another opinion. The quality of the arrangement depends partly on whether that advice is realistically available. A written statement that support exists is incomplete if nobody can explain who provides it outside normal hours or how urgent contact works. The job description and induction should make these arrangements intelligible. Where they are unclear, the doctor should ask for clarification before the uncertainty becomes a recurring clinical problem.

Delegation adds a further distinction. Giving a task to another person does not remove the need to consider whether the task is appropriate, whether instructions are clear and whether suitable supervision is available. A doctor accepting a delegated task needs to recognise when help is

required. The GMC's detailed guidance on delegation and referral should be used for the professional obligations.[7] The practical employment implication is that supervision is work. If the service expects a doctor to provide it regularly, the relevant role description and job plan should make the demand visible.

For example, a department may appoint a new clinical fellow and assume that an experienced SAS colleague will provide day-to-day support. The SAS doctor may be willing and capable, but several matters still need agreement. What decisions can the fellow make independently? When must the supervisor be available? Who covers absence? What educational assessment is expected? Does the supervisor have the access and authority needed to address concerns? Answering these questions helps both doctors. Leaving them implicit can make support depend on interruptions that nobody has included in the workload.

An expanded clinical scope should be approached as a planned change. Define the additional activity, the evidence of readiness, any required training or local authorisation, and the arrangements for initial review. Consider what existing work must change to make room. An employer's wish to improve capacity does not establish that a particular doctor is ready; the doctor's enthusiasm does not establish that the service is equipped. Both sides need an account of the conditions in which the new work can be undertaken. The result may be a staged arrangement rather than immediate independent practice.

Avoid describing a doctor as equivalent to an entire specialty merely because they undertake some work also performed by consultants. That phrase can obscure differences in breadth, recency and the intended role. The more useful account is concrete: the doctor manages a specified service independently, contributes to specified governance work, and obtains advice through a defined route. This evidence can support recognition and progression without an overbroad claim. It also allows areas for further development to be identified honestly, which is essential when preparing for a different post or regulatory application.

Finally, scope belongs in communication with patients and colleagues as well as in employment documents. People need an accurate understanding of the doctor's role and the arrangements for their care. A title may need a short explanation, especially when patients are unfamiliar with SAS grades. That explanation should be clear and confident without implying a status the doctor does not hold. The objective is to help the patient understand who is caring for them and how decisions are supported. It is not to reproduce the complexity of NHS employment terminology at the bedside.

Review the scope when a service changes its patient group, facilities or available support, even if the job title remains unchanged.

## Formal authority and organisational responsibility

An experienced doctor may influence decisions because colleagues trust their judgement. Formal authority is different: it identifies the decisions the organisation has empowered a role to make. Influence can help a proposal succeed, but it cannot always authorise expenditure, change staffing or approve a policy. A doctor who accepts a leadership function should understand this distinction before accepting broad accountability for its results. Otherwise, the role can become a place to send unresolved problems without providing the means to resolve them.

Ask for the purpose of the role in terms that can be tested. Is the doctor expected to advise, coordinate, approve, investigate or deliver a defined service? Those verbs imply different arrangements. An advisory role may reasonably end with a recommendation to a decision-maker. A delivery role may require access to resources and authority to direct specified work. A coordinating role may need an agreed route for resolving disagreement between teams. None is inherently superior. The difficulty lies in using the language of one while giving the doctor only the powers of another.

The reporting relationship should make the next step clear when action exceeds the role's authority. A leadership description that names a senior manager is useful only if the arrangement explains how decisions are escalated and reviewed. Who considers a request that cannot be funded? Who accepts a service risk that remains unresolved? Who can change the remit when assumptions prove wrong? These questions are particularly important when a doctor works across divisions or organisations. Personal relationships can facilitate action, but the role should remain workable when the people change.

Time belongs in the same discussion. A function cannot be assessed fairly if its duties are extensive but its practical time is undefined. Ask how the additional work will fit with clinical commitments, what meetings or preparation it requires, and which competing priorities take precedence. A title without such arrangements may give public recognition while leaving the work dependent on unpaid or unrecorded effort. Chapter 19 explores leadership in more depth; the essential point here is that an appointment should connect its purpose with the authority and capacity needed to fulfil it.

Daniel's governance meeting provides a useful example. If his role is to assemble information and make recommendations, the record should identify who decides whether those recommendations are accepted. If he is

expected to implement changes, he needs to know which staff, systems and budget he can use. The meeting minutes should distinguish a recommendation from an authorised decision. This protects the clarity of the governance record and avoids treating a doctor's attendance or signature as acceptance of responsibilities that were never explicitly delegated.

Some functions have specific statutory or professional eligibility requirements. Do not assume that a generic leadership appointment confers the authority to perform them. A role name familiar from one service may have a particular legal meaning in another. When that matters, retrieve the relevant legislation, professional requirements and appointment documentation. The safest general habit is to ask what establishes the authority for the precise decision, rather than to infer it from seniority. Individual advice may be necessary where an employer's expectation and the formal source do not agree.

It is reasonable to ask these questions before accepting a role. It is also reasonable to ask them when a role has changed. The request need not begin as a challenge to management. It can begin as a proposal to make the arrangements usable: confirm the remit, identify delegated decisions, record dependencies and set a review date. If an unresolved mismatch remains, preserve the correspondence and seek appropriate advice. The aim is an accurate allocation of responsibility, including the responsibilities that remain with other parts of the organisation.

Include an end or review date for temporary authority. A short-term appointment should have an identifiable point at which its continuation, handover or withdrawal is considered, rather than remaining indefinitely in an uncertain state.

## Specialist grade and the Specialist Register

The distinction between Specialist employment and specialist registration deserves deliberate attention because the same word is used in ordinary conversation for both. The employment grade is established through an appointment or applicable regrading process under the relevant terms. The Specialist Register is maintained by the GMC and records a separate regulatory status. A doctor should never be presented as holding one merely because they hold the other. Check the employment documents for the grade and the GMC register for the regulatory position.[2,6]

Imagine three doctors attending the same clinical meeting. Priya is employed as a Specialist and is not entered on the Specialist Register. Rowan is employed as a Specialty Doctor and is entered on the Specialist Register. Samira is called a specialist clinician locally, holds a local contract

and is not entered on the Specialist Register. All three may contribute valuable expertise. Their employment and regulatory situations are nevertheless different. Calling each of them specialist without explanation conceals precisely the distinctions that would matter in a contract discussion or an application.

Priya's appointment needs to be understood through the requirements of her post and the applicable employment framework. Her grade does not establish that the GMC has assessed her for entry on the Specialist Register. If she decides to seek that registration, she must identify the appropriate GMC route and its evidence requirements. Her current work may provide relevant evidence, but it will need to be mapped to the regulatory application. A successful employment assessment cannot simply be substituted for a different assessment by a different decision-maker.

Rowan's situation shows the converse. Entry on the Specialist Register does not rewrite the contract of the job currently held. It may be important to eligibility for another appointment, but it does not automatically change the existing grade or salary. Rowan may choose to remain in the current role, seek another post or discuss a different arrangement with the employer. The decision should be based on the relevant vacancy or employment process, not an assumption that a new register entry has already made that change. The distinction can prevent avoidable disappointment and an incorrectly framed request.

Samira needs to explain the local title accurately. If the term refers to a defined clinical function rather than a national grade, that explanation can sit alongside the formal employment title. Her experience should be described through the work, its context and supporting evidence. There is no advantage in obscuring the contract to make the title appear more familiar. A prospective employer needs to assess whether the evidence meets its requirements, and that assessment is easier when the candidate's account distinguishes a local description from an externally conferred status.

Consultant appointment is a further, related question. The GMC explains the role of specialist registration in NHS consultant appointments and identifies the exception concerning foundation trusts. That exception must not be generalised into a claim that every doctor can be appointed to every consultant vacancy, or that an employer has no other obligations. The employing organisation, post and applicable legal framework matter.[2] Readers considering such an appointment should examine the exact requirements and obtain advice where necessary. The book's employment chapters do not treat one exception as a substitute for appointment due diligence.

The Portfolio Pathway belongs on the regulatory side of this distinction. It is a route through which relevant training, qualifications and experience may be assessed for specialist or GP registration, subject to the applicable GMC requirements. The evidence needed is specialty-specific and must be checked against current guidance.[8] An appraisal portfolio, a strong curriculum vitae or a senior job title may contain useful material but should not be assumed sufficient. Chapter 18 explains how to build the evidence map, obtain verification and plan the work without promising a successful outcome.

This distinction should appear in a doctor's own correspondence. If seeking a Specialist post, name the employment grade and the vacancy. If seeking specialist registration, name the GMC route and intended specialty. If asking for development support, specify which destination the evidence is intended to serve. Managers can then respond to the right question, and advisers can identify the controlling source. Precise language is especially valuable when the doctor is pursuing both routes, because the experience gained may overlap while the applications, criteria and decisions remain separate.

Feedback should be kept with the process that produced it. An employment panel may identify a need for stronger evidence of leadership in that particular service. A regulatory assessor may require material addressing a different curriculum requirement. Both comments can inform development, but neither should be paraphrased as a universal finding about the doctor's seniority. Retain the original wording and connect the proposed response to the criterion being assessed.

## A document test for ambiguous situations

When documents appear inconsistent, resist the temptation to choose the one that supports the preferred answer. First define the discrepancy. Does the contract name one grade while payroll uses another? Does the job description omit a duty that the service routinely expects? Does a local title imply a function for which there is no appointment record? Different discrepancies need different inquiries. A short factual statement is more useful than a broad allegation that the records are wrong. It also makes it possible to check whether an apparent inconsistency is simply different terminology used for a legitimate purpose.

Build a comparison sheet with five entries: grade, contractual source, local title or role, scope of practice and register status. Under each, record the evidence and date. For grade, start with the appointment and any variation. For contract, record the national or local terms identified in the

agreement. For role and scope, compare the job description, job plan and current service arrangements. For register status, use the current GMC entry. The sheet is a preparation tool; it does not decide the legal effect of conflicting documents.

Add a separate line for formal organisational authority when the question concerns leadership or governance. Identify the appointment letter, role description, delegated decisions and reporting relationship. This prevents a clinical job description being used to answer a question about management powers. If no document can be found, record that absence as a question rather than evidence that the power either exists or does not exist. Ask the authorised person to explain the arrangement. An organisation may be able to supply a record that was not included in the doctor's own file.

Next, identify what changed and when. A dated chronology may show that a duty was added temporarily, extended later and never incorporated into the next job plan. It may reveal that payroll implemented a variation before the doctor received the final letter. It may show that a local title was introduced for patient communication without any intention to alter grade. These explanations lead to different actions. The chronology should separate documented events from recollection and should not include speculation about motives. Keep the underlying correspondence available through appropriate secure arrangements.

Daniel can use this test to prepare his second meeting. His grade is not disputed. The central discrepancy is between current service expectations and the recorded role. He can identify the additional site, supervisory function and governance work, with the relevant dates and available evidence. He can then ask for a revised description of duties and a job-plan review. A separate section records his interest in a Specialist role and asks which route the employer uses. The same evidence informs both discussions, but the requested decisions remain clearly separated.

Put a specific question to the person who can answer it. For example: please confirm whether the attached terms form part of my current contract; please identify the agreed authority for this additional responsibility; or please confirm how this duty is represented in the current job plan. Ask for a written response where the answer affects ongoing arrangements. This is usually more productive than circulating a large document bundle with a general request for recognition. It allows an adviser or manager to identify what they know, what needs checking and who else must respond.

Keep original records intact when preparing the comparison. Annotate a separate working copy or index, and distinguish later explanations from the document as issued. That preserves a reliable chronology for anyone asked

to review the question and prevents a helpful personal summary being mistaken for the agreement itself.

Preserve distinctions in the record of the meeting. Note what was agreed, what remains disputed, what information will be obtained and when the issue will be reviewed. Do not treat silence as agreement or a provisional discussion as a final contract variation. If a proposed change has important financial, professional or legal consequences, seek advice before relying on it. A short response deadline should be identified early. The document test is intended to improve preparation; it is not a reason to postpone timely representation while attempting to make the file perfect.

At the end of the exercise, the reader should be able to state the position without ambiguity. I am employed in this grade under these terms; I perform these duties within this scope; I hold this additional role and this register status; and the decision I am requesting concerns this particular discrepancy. Some questions will remain unresolved, but they will be visible. The next chapter adds the national context, because even a carefully defined question can produce a wrong answer if it is taken to the wrong country's contract or process.

Chapter 3

# The four nation map

## What remains UK wide

Aisha receives an attractive offer from a Welsh health board after working in England. The clinical duties look familiar, and the grade has the same name. She expects the move to be largely administrative. Her first questions concern the start date and rota. Only later does she discover that she needs to confirm different contractual documents, arrange access to a different appraisal system and understand a national progression process that colleagues describe in unfamiliar terms. The move is within the UK, but several of the systems surrounding her work have changed.

The starting point is to separate professional regulation from the organisation of healthcare employment. GMC registration and the licence to practise do not become Welsh, Scottish, English or Northern Irish credentials when a doctor moves. Good medical practice provides a common professional reference for doctors across the UK.[3] The employment agreement and the systems through which a doctor demonstrates and supports practice still require local and national examination. Holding the same regulatory status does not mean that the employer, contract or administrative process remains the same.

Revalidation illustrates the distinction. The GMC makes the licensing decision; a responsible officer or suitable person may make the relevant recommendation under the applicable arrangements. Doctors need to identify their connection correctly, especially when working for several organisations or changing employment. The GMC's connection tool provides a structured starting point.[9] Do not simply assume that the most familiar employer or the organisation used for the previous appraisal remains the correct connection. Confirm the position and arrange the transfer of relevant information through the appropriate channels.

An appraisal system is a means of organising the process, not a separate national licence. Changing the platform should prompt a practical review of access, information transfer and the next appraisal arrangements. It should not be interpreted as a need to begin professional evidence gathering from nothing. The doctor's previous work remains part of the whole scope of practice, but the receiving organisation may need it supplied in a particular way. Aisha should ask what information is required and who will coordinate

the transition, rather than trying to reconstruct the entire record without guidance.

UK tax rules also intersect with national variation. Pension tax questions may involve UK legislation and HMRC guidance, while personal income-tax treatment can differ according to the applicable national arrangements and individual circumstances. Scotland, for example, has different income-tax bands.[10] The location of the hospital alone is not a complete tax analysis. A cross-border worker should avoid assuming that either the employment nation's payscale or a colleague's take-home pay explains their own position. Chapter 21 addresses pension mechanisms and the points at which specialist advice is needed.

Other laws and procedures cannot be assumed identical merely because the professional regulator is shared. Healthcare and employment questions may engage different legislation, institutions or processes across the nations. A book can provide a comparison method, but it should not invite the reader to transplant a legal provision without checking its territorial application. This is especially important when a deadline, statutory function or formal challenge is involved. General professional guidance may explain why a concern matters while a separate national source determines the route through which it must be addressed.

For Aisha, the practical consequence is a divided checklist. She needs to maintain the accuracy of her GMC information and confirm her revalidation connection. Separately, she needs to establish the Welsh employment terms, appraisal arrangements and local support. Completing one side does not complete the other. This approach also helps a doctor who remains with the same employer but begins a second role elsewhere. The professional account may encompass both roles, while each employment retains its own documents, duties and administrative requirements.

Plan the timing of access changes too. A departing employer's account may close before the next appraisal. Ask in advance how essential records will remain available through authorised channels, rather than attempting hurried personal downloads.

## What is devolved or separately negotiated

The four nations do not provide four interchangeable versions of a single employment manual. They have their own health systems, contractual documents, pay arrangements and professional-support structures. Even where reforms share a history or familiar terminology, the operative documents must be checked separately. Similar wording is a useful clue about where to look, not proof that every schedule or implementation

decision is identical. The reader should establish the nation, grade and contract version before applying a provision found through an internet search.

Begin with the issuing organisation. A government circular, jointly agreed national term, employer implementation guide and professional association commentary have different functions. One may establish or communicate a rule; another may explain how it is put into effect; a third may help the reader understand a practical difficulty. Keep those functions visible in the source record. A helpful explanation can remain useful even when it is not the controlling authority, provided the reader knows where the operative provision is found and which circumstances it addresses.

Then establish the document's status. Is it current, superseded, proposed or retained for historical reference? A national page may link several versions because doctors remain on different contracts. The newest publication date does not mean that every existing doctor has moved to the newest terms. Conversely, a contract with an older name may have later amendments. Record the version and any relevant variation rather than relying on the filename alone. Where there is doubt, ask the employer or an appropriate representative to confirm the agreement that applies to the individual post.

Charters and development frameworks need their own reading. They can describe expectations about support, recognition and professional opportunity, and they can provide a useful basis for reviewing local practice. Their wording should not automatically be presented as an individually enforceable contractual clause. Ask how the commitment is implemented, what the relevant contract says and which local mechanism provides the promised support. This preserves the practical value of the document without overstating its legal effect. A gap between a commitment and delivery may require organisational attention even when the remedy is not a simple contractual claim.

Progression is an area where comparison must be especially precise. Wales and Scotland have published national regrading or career-progression frameworks, while the England and Northern Ireland chapters focus on preparing for competitive Specialist posts under the relevant arrangements.[4,5,11] The existence of one country's route does not establish the same route elsewhere. Nor does a route's existence mean that every doctor can use it successfully. The later chapters examine the criteria, evidence and process. Here, the task is to find the correct route before investing effort in a submission designed for a different system.

Pension administration provides a practical example of a split that does not follow a simple four-column pattern. NHSBSA is the relevant NHS pension administrator for England and Wales; Scotland uses the Scottish Public Pensions Agency, and Northern Ireland has the HSC Pension Service.[12–14] An employment move may therefore be within the same administrative scheme context or involve another administrator. Do not infer what happens to existing benefits, transfers or records from that broad map alone. Obtain the appropriate scheme information and an individual explanation where the move has financial consequences.

Local implementation remains a necessary final layer. A national term may establish a process while the employer identifies its contacts, forms and meeting arrangements. The local layer should be consistent with the applicable source, but it can still contain details essential to action. Record both: the national authority for the requirement and the employer's current method of handling it. If they appear inconsistent, ask for clarification with the relevant passages and dates. Avoid allowing an undocumented local custom to be treated as national policy simply because it has been followed for years.

A useful source navigator therefore records the topic, nation, issuing body, document title, operative date and relevant section, followed by the local contact. Add the date on which the source was checked. For a time-sensitive action, save the version relied on through appropriate arrangements. This takes a little preparation but makes subsequent advice much more efficient. Instead of asking which rule is correct in the abstract, the reader can ask whether this particular provision applies to this contract and these facts at this time.

Check the status again when a decision is delayed. A document retrieved during an early career conversation may have changed by the time an application is submitted. Keep the earlier version for the record, but verify which version governs the action.

## England

For a national SAS contract in England, NHS Employers is an important source of contractual and implementation materials. Its 2021 resource collection links the Specialty Doctor and Specialist documentation.[1] Start with the terms that apply to the post, then use the accompanying material to understand implementation. Do not treat every document in the collection as interchangeable: a model contract, capability framework and practical guide answer different questions. An individual appointment still needs to identify the relevant agreement and any later changes.

The first local contacts will commonly include medical staffing and the clinical manager responsible for the role, with professional representation where required. Ask medical staffing to confirm the contract and relevant employment records. Ask the clinical manager to explain the service, duties and review arrangements. A question may need both perspectives. For example, the manager may confirm that a regular teaching responsibility is expected while staffing clarifies how the additional role is recorded. Neither answer alone necessarily establishes the complete arrangement.

England's SAS Charter provides a further reference for considering the quality of the employment environment.[15] Use it to structure questions about how the employer supports SAS practice and development. Ask who owns local implementation and how doctors can raise a gap. The most useful conversation connects a stated commitment to an observable arrangement, such as access to an appropriate development discussion or a recognised local support role. Avoid leaving the inquiry at the level of whether the organisation generally values SAS doctors; most organisations will agree with that statement without it determining what happens next.

For appraisal and revalidation, the doctor should confirm the designated-body connection and the employer's process rather than assuming one universal software platform. NHS England's medical-appraisal resources provide supporting material, but the actual submission arrangements need local confirmation.[16] Before changing posts, ask how completed appraisals and relevant governance information will be transferred. A doctor with external practice should explain that work to the appropriate appraisal and revalidation contacts so the professional account remains complete. The existence of an employer portal does not define the entire scope of practice.

Senior progression should begin with the destination. If the aim is a Specialist post, examine the role, the applicable person specification and the evidence of capabilities. If the aim is specialist registration, use the GMC route. If a doctor on a local contract is considering a published transfer or permanency arrangement, establish its current eligibility and scope separately. These discussions may involve some of the same people, which makes careful naming even more important. A manager's support for development is not itself confirmation that a particular appointment process has been completed.

Consider Priya, who is interested in a Specialist vacancy in another English trust. She should compare the actual service with her current scope before preparing the application. A familiar specialty name may conceal different clinical breadth, on-call expectations or governance duties. She can then identify evidence relevant to the vacancy and questions for the

prospective employer. This is more useful than submitting the same generic senior-career narrative to every post. Chapter 17 develops the application method; the national map establishes which contractual and recruitment sources should inform it.

NHSBSA's member hub is the starting point for the relevant NHS pension information, alongside the doctor's own records and employer pension contact.[12] A change of grade, employer or working pattern is a reason to check records and identify potential questions, not to assume a particular tax outcome. Keep pension and employment inquiries connected but distinct. Payroll can explain reported pay and service; an administrator can explain scheme records and procedures; tailored financial or tax advice may be needed to compare choices. Sending every question to one contact can leave important parts unanswered.

Finally, check the source owner and date when an English organisation or process is changing. A webpage may remain useful during a transition, but an old contact or form may no longer be the right route for action. Use the current official signposting and retain the underlying document reference. This habit is more durable than memorising an organisational chart. It also prevents a proposed reform, a communication about future change and an operative requirement from being treated as if they have the same status.

## Wales

NHS Wales Employers' SAS resource page is the main starting point for the national contractual map. It distinguishes the 2008 arrangements from the post-2021 framework and links updated 2024 terms. It also identifies the All-Wales career-progression or regrading policy approved in May 2025 and the centrally managed application route.[4] These facts establish where the reader should look. The precise eligibility, evidence, timescales and outcome provisions must come from the operative documents, not from a general statement that Wales offers regrading.

Aisha should therefore request confirmation of the terms for her new appointment rather than assuming that her English contract transfers unchanged. The offer, job description and initial job plan need to be read together. She should ask how previous service is assessed for relevant employment purposes and which information is needed to establish her starting position. Those are questions to resolve through the applicable agreement and authorised advice. A colleague's experience of a different move may help her identify a question but cannot determine the answer to her own appointment.

Health Education and Improvement Wales provides the Medical Appraisal Revalidation System, known as MARS, to support appraisal and revalidation in Wales. Medical MARS and GP MARS have separate routes.[17] Aisha needs the appropriate registration and local appraisal arrangements for her role. The practical transition should include confirmation of access, the planned appraisal date and the relevant information from her previous employment. She should not assume that an existing appraisal record will appear automatically in a new system simply because both organisations recognise the same professional purpose.

The employment and appraisal conversations should remain connected without being collapsed. If Aisha identifies a development need at appraisal, she may need a separate agreement about experience or time in the job plan. If the manager changes her duties, the appraisal account may need to reflect the altered scope. The platform can support the record, but it cannot replace either discussion. A useful first-year plan identifies the manager, appraisal contact and any educational support, then shows which person is responsible for each practical arrangement.

For Eleri, an experienced Specialty Doctor in Wales, the national progression route raises a different question. She should begin by identifying the current policy and application route, then assess how her practice and the service relate to its requirements. A general claim that she has worked at a senior level for years may be insufficiently precise. The evidence needs to address the actual criteria and the nature of the proposed work. Chapter 15 develops that preparation in detail. The introductory map deliberately does not turn the existence of the route into a promise of regrading.

Eleri can prepare usefully before submitting anything. She can make an accurate account of her current role, gather appropriate evidence of capability, identify the relevant service context and ask how local discussions connect with the national process. She should distinguish verified achievements from planned development and distinguish the service's present requirement from a personal aspiration. This is original preparation work, not a substitute for the prescribed form. Where the policy asks a specific question, the evidence should answer that question rather than rely on a broad narrative of commitment or popularity.

The Wales SAS Charter and associated materials can help the reader examine the support available locally.[4] They should be used with the current contractual framework and employer arrangements. Ask how a stated commitment is delivered, who coordinates it and what evidence would show whether the arrangement works. A doctor seeking development may need

access to experience rather than another generic course. A doctor undertaking leadership may need a clearer remit and time. These distinctions make a charter-based conversation practical and help the organisation identify what it can change.

NHS pension administration for Wales sits with NHSBSA, as it does for England.[12] This shared administrator does not make every detail of two employments identical. On moving, check that the employer has the information required for accurate service and pay reporting and that the member's own details are current. Where there are existing benefits, additional employments or planned retirement choices, seek an explanation of the individual position. The fact that a move remains within one broad administrative setting should not discourage a basic reconciliation of the records.

Before Aisha's first review, she can test the move against a short practical sequence. Has the employing organisation confirmed her terms? Does the agreed work match the job description? Is support accessible in practice? Are appraisal and revalidation arrangements clear? Has the pension record been checked through the proper route? Are development ambitions being discussed with the person able to support them? None of these questions requires her to become an expert in every Welsh system. They require her to identify the correct source and obtain the confirmations that make the new role understandable.

## Scotland

For Scotland, begin with the relevant Scottish contractual documentation and published circulars. A document from England may explain a familiar concept while providing the wrong operative terms. The national publications service is an important route to the Scottish source record. Retain the circular identifier, date and any annexes when a provision matters to a decision. If a later document amends an earlier one, the amendment must be considered with the underlying terms. A title or publication year alone cannot establish the complete current position.

The published circular PCS(DD)2025/02 sets out a policy for career progression or regrading from Specialty Doctor or Dentist to Specialist grade.[11] It gives the Scottish progression discussion a specific national source. Because a circular can be amended or replaced, the reader must check the operative version before acting. This introductory chapter does not assume that a 2025 publication remains unchanged indefinitely. Chapter 16 examines the route separately from the Wales process and requires each procedural statement to be checked against the current Scottish policy.

Calum, an experienced Specialty Doctor in Scotland, wants to understand whether the route fits his circumstances. His first step is to establish the current eligibility and process, not to borrow a Welsh colleague's successful application. The Welsh document may illustrate how someone described their experience, but it cannot establish Scottish criteria or decision-making. Calum should build a preparation list from the policy that applies to him. That list should identify what is already evidenced, what needs clarification and what support or development may be necessary before an application can be assessed properly.

He should also separate an assessment of readiness from the organisation's handling of the process. A manager's encouraging view can be valuable but should not replace the specified steps. Equally, an unclear local answer should prompt a request for the relevant policy and contact rather than an immediate conclusion that no route exists. The useful question is precise: which operative document governs this application and how should it be initiated here? If different answers are given, retain them with dates and seek an authoritative explanation of the discrepancy.

Medical Appraisal Scotland provides national appraisal resources and information about the Scottish Online Appraisal Resource, SOAR.[18] A doctor moving into Scotland should confirm the appropriate account, local administration and information-transfer arrangements. The professional purpose remains whole-practice appraisal, but familiarity with a previous platform does not establish how a new organisation manages its timetable. Ask what must be available before the first appraisal and how previous records are handled. Resolve access difficulties early enough that they do not become confused with a failure to prepare the professional information.

Where Calum undertakes work outside his principal appointment, he should make the whole scope clear to the appropriate appraisal and revalidation contacts. The practical question is how information from the other work is obtained and considered, not whether each job requires a completely independent reconstruction of the same professional year. Use the GMC connection guidance for the regulatory relationship and the local process for administration.[9] If the answer is uncertain, obtain clarification rather than choosing the arrangement that seems easiest. Convenience cannot determine a prescribed connection.

The Scottish Public Pensions Agency administers the NHS Scotland Pension Scheme and provides member information about benefits, records, retirement and the public service pensions remedy.[13] Someone arriving from another nation should use the Scottish administrator's material and obtain advice about the treatment of existing benefits where needed. Similar names

for scheme sections should not be used to assume identical forms, deadlines or administrative steps. Retain records from previous membership and establish what information must be supplied through the correct route. Do not make a transfer decision solely because a move makes consolidation appear convenient.

An employment comparison should also distinguish gross salary from the personal financial result. Tax treatment, pension contributions and other circumstances can alter the relationship between an advertised figure and take-home pay. Scottish income-tax arrangements are one reason to check the individual calculation rather than relying on a colleague's experience.[10] This chapter does not provide a financial comparison between nations. It identifies the questions that should be taken to the correct source before a move is decided on the basis of an incomplete estimate.

Calum's national source record should end with the local implementation details: the person coordinating the progression process, the clinical manager for job planning, the appraisal administration contact and the pension route. Keeping those contacts beside the relevant documents makes future reviews easier. If an organisation or service changes its name, update the contact without losing the source history. The purpose is to preserve a reliable chain from national provision to the action required in the employing organisation. That chain is more useful than a folder of undated guidance collected without a decision in mind.

## Northern Ireland

Northern Ireland requires its own contractual source set. The Department of Health's SAS 2021 documentation page brings together Specialty Doctor and Specialist terms, model contracts, implementation material, capability documents and a Northern Ireland person-specification template.[5] Use those materials for the relevant appointment rather than assuming that an English template is an exact substitute. Shared origins in contract reform do not remove the need to check national wording and subsequent changes. The individual employer's current recruitment and employment records supply the further context needed for a decision.

A doctor considering an HSC post should identify the employing organisation, clinical service and grade before comparing terms. Ask which contract governs the offer, how the role is supported and what the service expects outside scheduled clinical sessions. A familiar title can coexist with unfamiliar arrangements for cross-cover, advice and referral. Due diligence should therefore examine both the formal agreement and the practical service. A candidate does not need to know every local detail before

applying, but should know which questions require an answer before relying on an offer.

For a competitive Specialist post, the relevant person specification is the starting point for the application. Compare its essential and desirable criteria with evidence of actual capability. Identify which elements are national and which reflect the particular service. A generic account of long experience may leave the panel unable to judge the requirements that matter most to the vacancy. Chapter 17 provides the detailed method. The national map prevents the reader from preparing a submission to a regrading process that has not been established as applicable to that employment.

Take the example of a senior SAS doctor in England considering a Northern Ireland Specialist vacancy. The doctor should not assume that successful practice in a current role proves readiness for every duty in the advertised post. Compare the patient group, clinical breadth, out-of-hours work, leadership expectations and available support. Then ask which previous experience can be evidenced directly and which differences require induction or development. This approach values existing expertise while taking the new service seriously. It also creates better questions for an informal visit or discussion with the recruiting team.

The Department of Health provides information about revalidation in Northern Ireland.[19] The doctor's current employing or designated body should confirm the practical appraisal arrangements, contacts and timetable. An older overview may remain a useful explanation of the system but should not be relied on for an unverified current deadline or platform. Obtain the operative local guidance before submission. As elsewhere, the GMC connection and licensing framework must be distinguished from the system used to collect and discuss professional information.[9]

The HSC Pension Service is the relevant pension-administration starting point for Northern Ireland.[14] A doctor arriving with previous NHS pension membership should retain the existing records and ask what happens under the applicable arrangements. The existence of another public-service scheme does not make a personal transfer or retirement choice self-evident. Identify the benefits already held, the information required and any time-sensitive options, then seek suitable advice. Employment induction is a useful prompt to begin this check, but the employer's welcome process should not be assumed to have resolved every pension question.

Legal and employment advice must also be appropriate to Northern Ireland. A general UK professional discussion can be helpful, but a statutory reference or process borrowed from Great Britain may not supply the correct rule. Where a concern involves a formal deadline or a proposed challenge,

obtain nation-specific advice early. Keep the national contractual documents and the employer's policy together so the adviser can see the basis of the decision. This is a practical safeguard against spending time preparing a response for the wrong procedure.

The four-nation navigator is now complete enough to use. For each employment, record the nation and employer, the current contractual documents, the local job-planning contact, appraisal arrangements, revalidation connection, progression route under consideration and pension administrator. Leave an explicit question where something is unconfirmed. Do not fill the gap with the arrangement used in another country. A blank marked for confirmation is safer and more useful than a confident answer copied from a superficially similar post. Give each outstanding question an owner and a review date, so that a careful comparison leads to a completed check rather than another unfinished list.

Before a move, compare the two navigators side by side. Identify what remains stable, what must be transferred, what must be agreed afresh and which decision needs advice before a date is fixed. After starting, review the record against what actually happens. Aisha's move, Calum's progression inquiry and the prospective Northern Ireland application all use this same method, but they do not produce the same national answer. The reader is now equipped to examine an offer or an existing employment with the right documents. Chapter 4 turns that preparation into a systematic assessment of an SAS post.

Chapter 4

# Entering or changing an SAS post

## Reading the advert critically

The decision to accept a post begins before the interview. An advertisement offers a picture of the work, but it is usually a compressed picture assembled for recruitment. It may combine the department's ambitions, a salary range, standard human resources wording and details copied from a previous vacancy. Reading it critically means finding the propositions on which a decision can safely rest. An attractive description of a supportive department matters, but the applicant still needs to know who employs the doctor, which grade is offered and what happens on an ordinary Tuesday evening.

Farah is a composite doctor with substantial overseas experience in acute medicine. She is considering a post in England advertised as a senior clinical specialist. The advert refers to a Specialty Doctor salary range and opportunities to develop an autonomous practice. The attached terms, however, describe a locally employed clinical fellow appointment for twelve months. Farah has not discovered that the job is necessarily unsuitable. She has discovered that its title, pay reference and employment category answer different questions. Before comparing it with a national Specialty Doctor offer, she needs the employer to explain each element.

The first reading should therefore extract the stable facts. Record the legal employer, employing nation, substantive grade, contract identified by name and year, duration, stated whole-time commitment, principal base and other sites. Record whether the vacancy is new, a replacement or temporary cover. A fixed-term post covering another doctor's absence has a different planning horizon from a newly established permanent service post, even if the weekly duties initially look identical. An application deadline is not a substitute for a realistic proposed start date and the conditions that must be satisfied before work begins.

Read the hours and rota wording separately from the headline salary. A range may describe basic full-time pay rather than the total attached to this particular working pattern. Expressions such as participation in the medical rota, flexibility across sites or occasional additional duties deserve questions about frequency and scope. An apparently ordinary daytime role can carry substantial evening responsibility if the rota description is hidden near the end of an attachment. Conversely, a broad advert may overstate duties that

do not actually belong to the vacant post. Both discrepancies should be resolved in the recruitment record.

National contract repositories help establish what an employer means when it refers to SAS terms. NHS Employers maintains the England SAS contract resources, while the other nations have their own sources described in Chapter 3. A national pay scale mentioned in an advert is not enough to establish incorporation of the corresponding national terms. The offer needs to identify the applicable agreement rather than leave the applicant to infer it from familiar numbers or terminology.[1]

Promotional language can then be translated into observable questions. For excellent development opportunities, ask what recent appointees actually accessed, who agreed the time and whether the opportunity depends on filling vacancies. For a friendly team, ask how a doctor obtains clinical advice and how concerns are discussed. For a flexible post, ask which parts are genuinely open to negotiation. If an interest in education is encouraged, establish whether teaching is an optional interest, an expected responsibility or a funded appointment with defined time. These distinctions make the promises useful without dismissing them cynically.

Keep the advert and attachments as dated copies. Recruitment pages may disappear after the closing date, and revised documents may carry the same filename. Put questions into one short email so the recruiter can coordinate a reliable response. A useful opening is: I am interested in the post and would like to confirm the contractual grade, the applicable terms and the expected rota before applying. This is a normal professional enquiry. A department's willingness to explain the work can itself provide information about how the eventual appointment is likely to be managed.

If two adverts seem equivalent, compare the unanswered questions as well as the stated benefits. An apparently precise advert can omit the one condition that matters most to the applicant. Write that condition down before discussing the post: for example, a predictable non-working day, access to supervised practice or a particular geographical limit. Otherwise, enthusiasm during recruitment can displace the reason for considering the move.

## Testing the person specification

The person specification should explain why the successful applicant is equipped for the role. It is not simply a list of impressive qualifications. Read every essential criterion as a proposition requiring evidence, then ask how it relates to a real duty. A requirement for recent acute assessment experience is intelligible if the doctor will assess undifferentiated

admissions. A requirement for a particular qualification needs closer examination if equivalent capability is permitted elsewhere in the document. The task is to understand the employer's selection test before deciding whether the applicant can meet it honestly.

Create a working evidence map with one line for each criterion. Beside it, identify the best evidence, its date and the person or organisation able to verify it. For clinical capability, evidence might include a clearly described role, relevant supervised practice, assessed procedures or an appropriately authenticated record of responsibility. For teaching, a programme, feedback and a short account of what changed are more informative than saying teaching is a passion. For improvement, explain the problem, the applicant's contribution and the result, including limitations. The map should expose gaps while there is still time to ask useful questions.

Separate three kinds of gap. An evidence gap exists when the applicant has the capability but has not presented it convincingly. A development gap exists when further experience or assessment is needed. An eligibility gap exists when a required condition is not met. These call for different responses. Improving a supporting statement may resolve the first. A supervised development arrangement may address the second if the role permits it. Neither response changes an essential eligibility requirement unless the employer confirms an accepted equivalence or amends an erroneous specification through the proper process.

For Farah, the problem is initially one of interpretation. Her overseas title included the word consultant, but the UK advert asks for experience relevant to the duties rather than recognition of that title. She prepares an account of the patients she managed, decisions she made, supervision available and outcomes she can evidence. She avoids describing herself as holding a UK grade she has never held. Her application becomes stronger because it explains capability in terms the panel can assess, without asking the panel to infer equivalence from unfamiliar career labels.

Specialist registration needs particular care. The GMC Specialist Register concerns regulatory status; it is not the same thing as appointment to the Specialist employment grade. A person specification should be read for the precise registration requirements of the advertised role, including any additional legal or professional requirements that genuinely apply. If a Specialty Doctor advert appears to require specialist registration while its duties and other criteria suggest a different intention, ask for clarification before treating the wording as either valid or irrelevant. Do not silently remove a criterion from the application because it seems unnecessary.[2]

Desirable criteria also deserve attention, but they should not become a private barrier that prevents a suitable doctor applying. Ask what each desirable attribute would add to the department and whether the applicant offers another relevant strength. Someone with modest research experience may bring substantial expertise in service improvement or education. That does not entitle the applicant to rewrite the scoring system. It helps them explain their contribution while remaining accurate about the published requirements. Equally, a long list of desirable qualifications should not disguise a role whose essential clinical demands are insufficiently specified.

At interview, use questions to test the fit in both directions. Ask which capabilities need to be present on arrival, which can be developed and how that development would be supervised. If the panel describes immediate independent cross-cover beyond the advertised scope, explore the discrepancy rather than giving a reassuring answer that conceals uncertainty. The safest answer may be that the doctor has relevant experience but would need local orientation and assessment before undertaking a particular task independently. That is a professional account of readiness, not an admission that experience has no value.

Finally, distinguish a selection decision from a development judgement. An unsuccessful application may reflect competition, evidence presentation, an essential criterion or a mismatch with the service. Request specific feedback where available. Ask which criterion was not demonstrated and what would constitute stronger evidence. A broad statement that another applicant was more suitable provides little basis for planning. Specific feedback can guide a future application, but it should be tested against the next post's requirements rather than treated as a permanent verdict on the doctor's career.

## Job description and service reality

A job description becomes useful when it can be connected to a service that actually exists. It should explain the patient group, settings, principal duties, professional relationships and expected level of responsibility. The practical enquiry then concerns how those duties are delivered. A clinic described as a half-day commitment may require preparation, results management, correspondence and communication with other teams. An inpatient responsibility may extend beyond the ward round into discharge decisions and urgent advice. The aim is to understand the complete work, not to challenge every task before arriving.

Ask to see a representative timetable and the rota arrangements relevant to the post. Where possible, discuss the work with someone doing it and

someone who depends on it, such as a nursing lead or clinical service manager. They may describe different parts of the same system. A doctor may emphasise clinical complexity; a manager may explain throughput expectations; a nurse may identify when advice is hardest to obtain. Differences between these accounts are prompts for clarification. They are not automatically evidence that somebody is concealing the truth.

Follow a patient pathway through the proposed role. Who assesses the patient first, who makes the senior decision, who follows pending results and who receives the next call? Then follow the pathway after normal working hours. A statement that consultant support is available does not describe whether that support is on site, by telephone, shared across hospitals or dependent on a separate referral. The doctor needs to understand the route for urgent advice, review and transfer, including what happens if the first contact is unavailable. These are operational questions with direct implications for workload and safe practice.

Cross-cover deserves its own discussion. Covering a colleague's clinic after an agreed adjustment is different from assuming responsibility for another specialty's patients while continuing the original list. Ask whether cross-cover is routine, limited to emergencies or a response to vacancies. Establish what work is reduced when additional work is added. A rota can look fully staffed while relying on the same doctor to undertake two incompatible activities. The issue is not settled by saying that colleagues have always helped each other. The proposed arrangement must remain workable when ordinary demand becomes difficult.

The number of sites matters as much as their names. In the national Specialty Doctor post Farah is also considering, the principal base is the central hospital but the service includes two smaller units. She asks whether visits are scheduled, whether urgent attendance is expected and how travel fits the working day. The employer explains that one afternoon is allocated to a satellite unit and that urgent advice there is remote, with a separate emergency transfer pathway. This is a materially clearer job than the phrase work across the directorate. She can now assess both the clinical remit and the journey involved.

Facilities are part of the role, not an incidental comfort. Appropriate systems access, a place for confidential conversations, reliable communication, administrative support and suitable clinical equipment affect what can reasonably be delivered. If a doctor is expected to supervise others, there must be a practical opportunity to observe work and discuss it. If a role includes remote advice, the doctor needs access to relevant records and a clear account of what information the caller can provide. Missing

infrastructure often appears later as an individual delay or performance concern unless it is identified early.

Ask about the service's current pressures without assuming that a pressured service is a poor appointment. A difficult post may offer worthwhile work, supportive colleagues and a credible improvement plan. The important distinction is whether the employer can explain the pressure and what is being done. How many posts are vacant? Which functions rely on temporary cover? What changes are already approved? Which ambitions remain unfunded? An honest answer that a new pathway is under development can be more useful than an unqualified promise that staffing will soon improve.

Record the outcome as a short description of the ordinary week and the foreseeable difficult week. The ordinary week establishes the intended model; the difficult week tests its resilience. For example, what happens when the doctor covering the neighbouring ward is absent and the senior adviser is in another hospital? This exercise does not require a catalogue of every possible crisis. It identifies whether an escalation route and workload adjustment exist. Before accepting, the reader should be able to explain the role to another experienced doctor without relying on phrases such as everyone just manages or it will become clear once I start.

For a visit, prepare a few questions that require examples. Ask how the last unexpected absence was covered, how a difficult transfer was organised and when the job description was last revised. Examples make broad assurances easier to understand. They also let the applicant assess how the team learns from practical difficulties without asking anyone to disclose confidential details about colleagues or patients.

## Contract and pay due diligence

Once the role is understood, compare the offer with the governing terms and the applicant's own circumstances. Request the individual contract or proposed written particulars, the national terms incorporated if any, the job description and the proposed job plan. An offer letter may settle some questions while leaving others subject to checks or agreement. Read conditions carefully, especially before resigning from a current post, moving house or making a financial commitment that depends on the appointment proceeding. If the documents conflict on a material point, ask for a corrected version rather than relying on reassurance that the wording is standard.

Starting pay should be explained as a decision, not merely communicated as a number. Ask which scale and point are proposed, what experience has

been recognised, what evidence is required and who can review the calculation. Previous employment certificates should distinguish dates, grade, specialty, working pattern and relevant breaks. Different types of previous service may matter for different benefits. Recognition for salary placement does not necessarily establish the same recognition for annual leave, sick pay, redundancy or pension purposes. The reader should request an answer to each relevant question rather than asking vaguely whether all service counts.

Separate basic salary from every additional element. Identify payments for agreed additional work, on-call availability or other duties, and establish whether they are recurrent, conditional, time-limited or subject to review. Record the basis of calculation and the date from which payment applies. A quoted total can conceal the fact that a significant part depends on extra duties the doctor does not wish to undertake indefinitely. It can also make comparison with another offer misleading. Compare the underlying commitment and predictable pay first, then examine optional or variable work separately.

Pensionability requires a specific answer. NHSBSA explains pensionable membership through its member guidance for the scheme it administers; Scotland and Northern Ireland have separate administrators. The fact that a payment appears on an NHS payslip does not by itself answer every pension question. Give payroll or the pensions team the precise proposed payment and working arrangement, and ask how it will be treated under the applicable scheme. Chapter 21 develops the mechanisms and tax interfaces in detail. At appointment, the immediate task is to prevent an unexplained assumption becoming the basis of a long-term financial decision.[12]

Offer comparison record. Copy these fields for each offer: employer and nation; grade and governing terms; duration; basic commitment and rota; basic pay and separate additions; recognised service; leave; pension questions; sites and travel costs; development and support; conditions still unresolved. Beside an unanswered field record the decision-maker, evidence requested and reply date. Keep a final field for personal priorities and the reason for choosing.

Farah's completed comparison favours the national Specialty Doctor appointment in England. The local clinical fellow offer has higher headline pay but includes extra work and a twelve-month term. The national offer provides the clearer development arrangement she values. She accepts it after material conditions are confirmed. This composite choice reflects her priorities; another applicant could reasonably choose differently.

Pay protection and recruitment incentives need their own terms. Ask what is protected, for how long, whether future awards affect it and what happens after a change of hours or role. If relocation expenses, a joining payment or funded training carry repayment conditions, read the trigger, amount and repayment period before accepting. A benefit that is attractive on arrival may restrict a later move. The purpose of due diligence is not to reject such arrangements automatically; it is to understand their cost if the appointment does not develop as expected.

Check notice, any probation provision, the treatment of a fixed-term end date and the process for agreeing changes. There is no single probation arrangement that can safely be assumed for every SAS or locally employed appointment. If the employer proposes a probation period, ask what will be assessed, what support is offered and how it relates to the contract. Where a decision has significant legal or financial consequences, obtain individual advice before signing. A contract review is most useful while the terms can still be clarified and before disagreement becomes entangled with a move already made.

Keep financial comparison separate from personal preference until both are clear. A shorter commute may make a lower headline salary attractive, while a fixed non-working day may be more valuable than optional extra sessions. Distinguish recurring costs from relocation expenses and a recruitment payment from annual income. Retain the comparison so the decision can be revisited if an unresolved condition changes.

## Professional and immigration checks

Appointment involves several forms of assurance that should not be confused. Registration and a licence concern professional status; immigration permission concerns the right to undertake work; employment checks concern the organisation's recruitment responsibilities; local induction and credentialing concern readiness for this role. Completion of one does not replace the others. A doctor's extensive experience may satisfy a clinical criterion while a verification process remains incomplete. Equally, successful recruitment checks do not prove competence for every duty that someone later adds to the rota.

The NHS Employers employment standards framework is a useful starting point for understanding the checks used by employers in England, including identity, right to work, registration and qualifications, employment history and references, relevant criminal-record checks and work health assessment. The employer should explain its requirements and the process applicable in its nation. Supply information through the

designated recruitment route and retain a record of what has been requested and completed. Where names, dates or translations differ between documents, explain the discrepancy early rather than allowing it to appear as an unexplained inconsistency.[20]

GMC registration must be appropriate to the work. Confirm the register entry and licence status, and raise any condition or restriction that affects the proposed duties through the proper process. If a new role changes the scope of practice, ensure the department understands the change rather than assuming that registration alone settles the competence question. Good medical practice requires doctors to recognise the limits of their competence and work within them. Local orientation, supervised experience or assessment can therefore be necessary even for an experienced doctor joining a familiar specialty.[3]

For a doctor using a Health and Care Worker visa, a move to a different employer generally requires an application to update the visa. The official guidance states that the new job must meet the relevant requirements and a new certificate of sponsorship is needed. It also states that the doctor should not begin the new job until the new permission is confirmed. A prospective employer's enthusiasm, a planned rota start or a verbal assurance does not replace the required permission. Obtain current advice for the actual immigration route and family circumstances rather than applying another doctor's experience by analogy.[21]

Farah puts the immigration and recruitment milestones alongside her proposed start date. She asks who issues the sponsorship documentation, which checks must be complete first and how a delayed start would be managed. She does not assume that a recruitment officer can provide personalised immigration advice beyond their role. If the proposed arrangement includes work for another organisation, she describes that explicitly when seeking advice. The practical benefit is a realistic sequence: permission, employment readiness and service induction can be coordinated without pretending they are the same approval.

Indemnity should be checked before practice begins. The GMC requires adequate and appropriate arrangements covering the whole scope of medical practice. NHS or HSC clinical negligence arrangements protect the organisation in their defined scope; they do not supply every form of individual regulatory or medicolegal assistance. Discuss the actual role and any additional work with the relevant provider, including teaching, reports, private activity or work across organisations where relevant. Record the answer and review it when the scope changes. It is particularly unwise to

infer comprehensive personal support solely from the phrase NHS indemnity.[22]

Health information should go through the appropriate confidential occupational health process. The useful output for a manager is an understanding of fitness for the proposed work and any necessary support or adjustments, rather than an indiscriminate circulation of clinical detail. If an adjustment is needed for recruitment, induction or ongoing work, raise it in time for the organisation to act. The appointment should begin with the relevant arrangements understood, rather than a doctor feeling obliged to demonstrate that they can manage unaided until a preventable difficulty develops.

## Induction supervision and named support

An experienced doctor still needs induction. Familiarity with medicine does not confer familiarity with a local prescribing system, referral pathway or emergency response. Nor does prior NHS employment make every organisation's arrangements interchangeable. Induction should connect the doctor's existing capability to the new environment. The useful question is not whether the doctor has completed a collection of slides. It is whether they can perform the agreed work, obtain help and respond to a problem using the systems that will actually be available on their first working day.

Start with the tasks that carry immediate consequences. Can the doctor identify the responsible team, review the clinical record, prescribe, request investigations, acknowledge results and document a plan? Do they know how to obtain urgent senior advice, activate an emergency response and arrange transfer? Can they use the incident-reporting system and find the policies needed for their scope? An access checklist should distinguish requested, issued and tested. An account created on paper is not functional access if the password fails when the doctor arrives at a satellite clinic.

Ask for a named clinical contact and an agreed arrangement for early review. The contact's role should be explicit: clinical advice, supervision of unfamiliar work, educational planning or line management. One person may undertake several functions, but the functions should not disappear into the word supervisor. An autonomous SAS doctor may need orientation and peer support without a training-style supervision model. A doctor undertaking a new procedure may need a more structured assessment arrangement. Match support to the work and individual readiness rather than attaching a uniform level of supervision to the SAS label.

Aisha provides a contrasting composite example to Farah. At her first UK appointment, before the move from England to Wales described in Chapter

3, Aisha accepted a national Specialty Doctor post. The department recognised her relevant clinical experience and agreed a staged introduction to the local acute pathway. During the first weeks, a named senior colleague reviewed unfamiliar decisions with her, while she independently undertook work within her established competence. The plan stated what would be reviewed and when. It avoided both extremes: treating her as inexperienced in everything, or assuming that overseas seniority removed the need to learn a different system.

Educational support requires more than a name on an induction leaflet. Meet the SAS tutor or equivalent educational contact and ask how development opportunities are identified, funded and incorporated into work. Find the SAS advocate or other designated representative where that role exists, while recognising that an advocate may not provide individual legal representation. Ask who can help with appraisal arrangements, portfolio systems and access to teaching. The aim is to know whom to approach before a difficulty becomes urgent, not to collect a directory that will never be opened.

Reasonable adjustments should be made practical. In Great Britain, Acas explains the employer's duty to make reasonable adjustments for disability and the need for arrangements specific to the individual. Northern Ireland has a distinct equality framework and local guidance should be used there. A useful adjustment discussion identifies the barrier, the proposed response, who will arrange it and a review date. For example, specialist software is of little use if installation permissions remain unresolved. The doctor should not have to repeatedly disclose sensitive details to every person involved in implementing an already agreed arrangement.[23]

Meet the people who hold operational knowledge. Ward and clinic coordinators, pharmacists, administrative staff, therapists and experienced nurses often understand where the pathway works and where it becomes fragile. Ask how information reaches the medical team, what creates avoidable delay and what staff need from the new doctor. These conversations establish working relationships while exposing assumptions that a formal induction programme may miss. They also provide an early opportunity to introduce the doctor's actual role and authority, reducing confusion caused by unfamiliar titles.

End induction with a review of readiness rather than a ceremonial signature. Identify what has been completed, what remains unavailable and what temporary arrangements make the work safe meanwhile. If a critical gap persists, specify which duty is affected and who must decide the response. Retain a brief record, then revisit it after real work has tested the

arrangements. Induction is successful when the doctor can describe how the service functions and colleagues understand how to work with them. A completed form is evidence of a process, not proof that every practical need has been met.

## The first job plan and portfolio plan

The first job plan translates the appointment into an agreement about work. It should connect duties, time, objectives, location, supporting resources and review. Chapter 6 examines contractual mechanics in detail. At entry, the priority is to ensure that the plan describes the proposed role rather than an inherited timetable carrying somebody else's name. A document that lists clinics and ward rounds but omits the associated work gives the new doctor an incomplete starting point. It can also create an early appearance of underperformance when the schedule was never realistic.

Discuss the whole task around each visible activity. A clinic generates preparation, correspondence, follow-up and results. Supervision requires observation, availability and feedback. Governance work needs preparation and action after meetings. Do not assume that all such work belongs in the same contractual category; classification depends on the applicable terms and the nature of the activity. The initial discussion should establish what is required and how it is accommodated. Accurate description comes before allocation. Otherwise, the parties may argue about labels while overlooking the work that needs to be done.

Separate established duties from developmental ambitions. If Farah wants experience in a particular clinic, the plan should identify whether attendance is approved, who supervises it and what existing commitment will change. If the employer hopes she will later develop a service, that hope should not appear as an immediate delivery objective without resources or authority. A sensible first-year objective can be to assess feasibility and agree a proposal. It need not promise a new service before the doctor has understood the current one.

Make dependencies visible. Suppose a teaching objective requires access to a simulation room, release from clinical work and another colleague's participation. The doctor's action is only part of the plan. Name the person who will confirm facilities, the manager who will agree release and the point at which an alternative is needed if support is unavailable. This is not an exercise in transferring responsibility. It makes the objective achievable and allows a fair later discussion about what happened. Unrecorded dependencies often become a retrospective argument about motivation.

The portfolio plan should be equally proportionate. Begin with an accurate scope-of-work record, the agreed job description and job plan, induction outcomes and a small set of developmental priorities. Decide where supporting information will be kept and how confidentiality will be maintained. Do not start by copying every clinical document into a personal folder. Identify the evidence likely to be useful, who owns it, whether it can be appropriately anonymised and how the doctor's contribution can be verified. Chapter 12 develops this into a maintainable evidence structure.

Plan appraisal early. Use the GMC connection guidance to confirm the designated body or other appropriate route, rather than choosing a responsible officer simply because that person is familiar. Establish the local appraisal timetable and system, and find out what information needs to be transferred from a previous organisation. A job change does not erase the professional history that may be relevant to revalidation. Equally, a new employer should understand which information is legitimately available and how it will be obtained. Appraisal preparation should begin with connection and scope, not a last-minute search for certificates.[9]

For Aisha, a useful first-year plan contains three linked strands. She will become confident with the local acute pathway, develop her teaching contribution and establish a reliable appraisal record. The clinical strand has named support and review points. The teaching strand begins with a limited commitment that can be evaluated. The appraisal strand identifies the platform, due window and evidence sources. None of these strands promises promotion or specialist registration. They create a credible foundation from which she can make later choices about the direction of her career.

Agree a review after the initial period of practice, with a method for raising discrepancies sooner. Record who will attend and what evidence will be useful, such as a representative work diary and a note of recurrent interruptions. The first plan should be stable enough to guide work and flexible enough to correct genuine misunderstandings. It should not become an excuse to defer every difficult question until the annual cycle. If the role proves materially different from the offer, the doctor needs an early conversation grounded in the documents and the work actually being required.

Evidence collection can start with modest agreements that save considerable reconstruction later. If a senior colleague will observe practice, establish how feedback will be recorded. If the doctor joins an improvement project, clarify their contribution and access to an approved summary of results. If a teaching programme is planned, decide how feedback will be sought. These arrangements should serve learning and service delivery first.

Their portfolio value comes from an accurate account of real work, not from creating documents solely to make an application appear substantial.

## First ninety days

The first ninety days are a practical review period, not a universal contractual probation rule. They provide enough structure to prevent urgent daily work from consuming every opportunity to understand the appointment. Divide the period into preparation, initial orientation, testing and consolidation. The exact pace depends on the role, working pattern and individual needs. A part-time doctor may have had relatively few clinical sessions after a calendar month; an experienced doctor changing only one aspect of work may progress differently. Count meaningful exposure as well as elapsed time.

Ninety-day record. For each stage below record the action, responsible person, target date, completion evidence and unresolved issue. Use status words that mean something: requested, confirmed, tested or awaiting decision. Acknowledgement is not completion. Retain one record across recruitment, medical staffing and the department so that the doctor does not have to reconstruct each team's promises.

Before starting. Confirm material contract questions, start date, clearances, rota, reporting arrangements and induction contact. Record where to attend, required access and the owner of each outstanding condition. For a time-sensitive dependency, state what happens if it is not complete by the planned start.

First working days. Test clinical systems, emergency communication, handover and results responsibility. Meet the named clinical contact and agree how questions will be raised. Record the duties for which orientation remains incomplete and the temporary support agreed. The completion evidence is functional access and an understood pathway, not simply attendance at induction. If independent work is scheduled before essential preparation is complete, seek a safe arrangement immediately.

By the end of the first month, compare the advertised and agreed role with the actual pattern. Use a brief diary that records categories of work, significant interruptions and recurring mismatches without patient identifiers. Check the first payslip against the agreed salary and allowances, noting that a partial first month or timing of payroll changes may explain some differences. Ask payroll to explain discrepancies rather than assuming either error or correctness. Confirm that appraisal connection, education access and any adjustments have moved beyond a request into an operational arrangement.

The second month is a useful point for a focused review with the manager or clinical lead. Bring a short account of what is working, what differs and what decision is needed. Farah, now in her chosen appointment, finds that the satellite session routinely generates follow-up work on another day. She describes the work and asks where it should sit in the plan. She does not frame the problem as a complaint that the department failed to predict every detail. The issue is whether the agreed schedule can now be corrected to reflect an established requirement.

Some early concerns require a faster route. A missing login may be an administrative problem; repeated inability to access essential records during clinical decisions may be a safety problem. A delayed payment may be correctable through payroll; a substantial unexplained reduction affecting the agreement may need employment advice. The response should match the consequence and urgency. Preserve the evidence, use the appropriate reporting route and distinguish immediate patient-care action from the later contractual discussion. The ninety-day plan is not a reason to wait when a material risk is already apparent.

By the third month, review development and belonging as well as workload. Has the doctor had access to the promised experience? Is the supervision arrangement still appropriate? Are colleagues using the doctor in the role that was agreed? Has an informal extra duty become recurrent? Does the working pattern remain sustainable alongside travel and personal commitments? Answering these questions early can reveal a modest adjustment that prevents a much larger problem. It also helps the doctor recognise positive opportunities that were not obvious in the advert but can now be developed deliberately.

Before the final review, ask whether any unresolved matter depends on somebody who has left or changed role. Recruitment promises can otherwise become orphaned decisions. Send the relevant record to the current decision-maker with a concise explanation of the outstanding question. Where the answer is that an opportunity cannot now be offered, ask what alternative is realistic and whether the change affects the reason for accepting the appointment. A clear disappointing answer is still useful information: it allows an informed decision about development, negotiation or a future move.

The offer comparison sheet and the ninety-day record should eventually become a concise first-year plan. Retain the key facts, decisions, owners and review dates; archive duplicated correspondence rather than carrying everything forward. The outcome is not a guarantee that the post will remain unchanged. It is a shared account of what the doctor joined to do, how the

work has been tested and what must happen next. That account gives later job planning, appraisal and career development a sound starting point. It also makes a future move easier to evaluate because the doctor now knows which questions matter before accepting the next attractive advert.

Chapter 5

# Understanding the employment framework

## The hierarchy of employment documents

Daniel has coordinated a weekly multidisciplinary meeting for several years. His colleagues regard him as responsible for it, and the service relies on the decisions and follow-up it generates. The duty began as a short-term arrangement during a vacancy. His job description predates it, the latest timetable does not identify it and an old email says that the position will be reviewed. When Daniel asks for the work to be recognised in his job plan, a new manager replies that coordination is already covered by the general requirement to support the department. Daniel believes a long-standing agreement is being ignored. Neither has yet assembled the documents needed to decide what was actually agreed.

This chapter uses Daniel as a composite Specialty Doctor employed in England on national terms. His situation illustrates why a simple hierarchy of documents can be misleading. Legislation, collective agreements, national terms, an individual contract, a job description, a job plan and local policies do not merely occupy seven rungs on a ladder. Their effect depends on the question, incorporation, wording, timing and applicable law. A national document may supply a contractual process; a local policy may describe how to access it; an individual agreement may record the doctor's actual duties. Each can matter without deciding every aspect of the dispute.

Start by distinguishing a source of obligation from evidence of an agreement. Legislation can impose requirements that do not depend on whether the contract repeats them. Express contractual terms may be written or verbal; other terms can arise through legally recognised mechanisms. Acas explains that an employment contract is broader than the written statement of particulars and that agreement can be evidenced in several ways. This does not mean that any remembered conversation becomes binding. It means the enquiry cannot safely stop after reading one signed document.[24]

National terms need to be linked to the individual appointment. Establish the nation, grade, contract version and any relevant amendments. Then find the wording by which those terms apply to the doctor. A colleague's contract may help identify a missing document, but it does not establish the reader's

entitlement. The same department may include doctors on different national contracts, retained historical terms and local arrangements. An employer's general description of the SAS workforce does not erase those distinctions. The document map must describe the actual appointment being examined.

For each source, write down what question it can answer. The individual contract may identify the employer and contracted commitment. The job description may explain the role's broad scope. The job plan may record agreed activities and resources. A policy may identify the person to contact and the form required. Minutes and emails may establish when an additional duty was introduced. This method is useful because it prevents a document being asked to prove more than it contains. A timetable demonstrates what was scheduled; it does not necessarily explain why an omitted duty became expected.

Daniel's first task is therefore evidential. He obtains the offer and contract, the applicable national terms, his job description, successive job plans and the original coordination correspondence. He asks whether a later agreement replaced the temporary arrangement. He checks whether the manager's policy is current and whether it actually addresses this duty. He also records the work now required, because even a clear account of the original agreement may not describe the current service. Historical entitlement and present workload are related questions, but they should be capable of separate answers.

The reader's employment document map can be a single page. For each document record its title, date, source, purpose and unresolved question. Mark whether it is signed, agreed, draft or simply informational. Add the relevant passage rather than attaching an entire archive to every email. The map is a preparation tool, not a legal opinion. Its value is that a representative, manager or adviser can see what is known and what needs interpretation. A disciplined document set usually makes a stronger starting point than a confident assertion that one document automatically overrides all the others.

## National terms and local implementation

National agreements provide a framework within which local work must be organised. They cannot describe every clinic, hospital journey or educational responsibility. Local implementation is therefore necessary. It becomes problematic when the word implementation is used to conceal a change in the underlying agreement, or when a doctor treats every administrative choice as if it requires national negotiation. The useful question is what the local decision does: does it arrange an established

process, exercise an authorised discretion, seek a new agreement or conflict with a term that already applies?

Consider three examples. Requiring job plans to be submitted through a particular system may be an administrative arrangement. Scheduling the annual review within an agreed departmental cycle may organise the process. Reducing an agreed commitment or payment raises a different question about contractual authority and consent. The examples do not decide whether a particular action is lawful. They show why the reader should identify the substance of a change rather than accept its label. Calling something a rota update does not make its consequences merely administrative.

The NHS Employers England SAS repository provides national terms, model documentation and related resources, while Northern Ireland's Department of Health maintains a separate SAS contract collection. Their existence illustrates why implementation must begin with the correct national source. A form borrowed from another nation may be convenient, but its wording cannot safely be assumed to carry the same process or entitlement. For Wales and Scotland, use the national sources identified in Chapter 3 and the contract applicable to the individual doctor.[1][5]

Local discretion should be identified precisely. Ask who has authority to make the decision, the criteria they apply, what evidence they need and whether a review route exists. A manager may be able to agree a timetable adjustment but need another person's approval for a funded additional role. Medical staffing may explain contractual wording while a clinical lead decides the service's proposed priorities. If the doctor sends one broad request to everyone, responsibility can become diffuse. Splitting the request into decisions with named owners makes it easier to obtain a usable answer.

In Daniel's case, the service manager can confirm that coordination remains necessary. That is not necessarily the same as authority to change the agreed job plan or establish additional remuneration. Daniel therefore asks for two linked decisions: confirmation of the expected duty and a review of how its workload is accommodated. He avoids asking the manager to recognise his seniority as an undefined whole. The narrower request preserves the substance of his concern while giving the organisation a practical route to respond. A separate progression discussion can follow if the evidence supports it.

A local procedure should also be tested against the work it is intended to support. Suppose the system allows only fixed weekly activities, while the doctor undertakes a variable annual teaching commitment. The right response is not to distort the work until it fits a screen. Ask how the

organisation records that type of commitment and where the agreed explanation will sit. Software is a means of recording an agreement, not an independent source of contractual truth. A limitation in the form should be made visible before it creates a misleading account of the role.

When local wording appears inconsistent with national terms, frame the enquiry carefully. Identify the two passages, explain the practical difference and ask which is intended to apply. For example: The local instruction appears to exclude this category of work, whereas the attached national provision appears relevant to it; please explain how the local process gives effect to the provision. This is more productive than asserting that all local policies are invalid. It also helps a representative assess whether the problem is interpretation, incomplete implementation or an actual proposed contractual change.

Keep collective and individual issues connected without merging them. If several doctors encounter the same apparent inconsistency, a recognised representative route may be more effective than repeated individual correspondence. The common question can be considered collectively while each doctor's facts remain distinct. A department-wide solution still needs to fit different contracts and working patterns. Conversely, an individual arrangement that works well for one doctor should not be described as an entitlement for every colleague unless its basis genuinely supports that conclusion.

## Written particulars and incorporated documents

The document handed to a new employee is often called the contract, but it may be a statement summarising principal terms and referring elsewhere for detail. Acas distinguishes the written statement of employment particulars from the broader employment contract. In Great Britain, the main written statement is required from the start of employment, with some information permitted separately under the applicable rules. A doctor should obtain the statement promptly, but should also retrieve the terms and policies it identifies. The absence of a clause from the short document does not necessarily mean that no corresponding term exists.[25]

Northern Ireland must be treated separately. The official nidirect guidance describes the written-statement entitlement for employees employed for more than one month and provision within two months of starting. It also explains that some particulars may be supplied through other accessible documents. These are not interchangeable with the Great Britain timetable. A reader moving between nations should use the applicable rules rather than repeating a familiar deadline from a previous appointment. For a

dispute about compliance or remedies, obtain advice under the correct jurisdiction.[26]

Look for phrases referring to national terms, collective agreements, policies, schedules and amendments. Then request the actual documents, including the version relevant to appointment and any later changes said to apply. An intranet link may lead only to today's policy. That can be adequate for finding the current process but insufficient for understanding a decision made several years earlier. If the question concerns the introduction of a duty or removal of an allowance, the historical version and transition arrangements may be central to the explanation.

Incorporation is a legal question that may require interpretation. A document being available on the intranet does not automatically make every sentence a contractual term. Equally, labelling a policy non-contractual does not answer every question about how it may be used or whether other obligations apply. The reader should identify the relevant references and ask the employer or adviser to explain their effect. The practical skill is to recognise when the document set is incomplete, not to improvise a legal conclusion from a heading or disclaimer.

Check the personal particulars as well as the incorporated framework. Is the correct employer named? Are the grade, start date, contracted commitment, location and pay details consistent with the offer? Is earlier continuous employment recorded correctly where relevant? Are fixed-term dates and any agreed special arrangements clear? A discrepancy that appears minor can later complicate a calculation or dispute. Request correction while the recruitment record is recent, and retain the reply. It is easier to amend a wrong date at entry than reconstruct why it was accepted years later.

Build a compact document index rather than repeatedly downloading an entire policy library. Daniel's index identifies his individual contract, the national terms, relevant amendments, current job plan and the policies that bear on the disputed duty. Each entry includes the location of the original and the date he retrieved it. He keeps personal employment material securely and does not mix it with patient information. Where a document belongs to an employer's controlled system, he preserves enough detail to identify the authoritative version and obtain it through an appropriate route when needed.

The same discipline helps when an organisation says that the doctor has already agreed a change. Ask for the document, date and form of agreement relied upon. A signed acknowledgement of receiving a policy may not answer the same question as agreement to alter a term; the wording and

circumstances matter. Avoid making assumptions in either direction. The reader should leave this enquiry with a clear account of what was supplied, what was accepted, what remains disputed and which question requires individual advice. That is a much stronger position than arguing over the everyday meaning of the word contract.

When a referenced document cannot be found, record the failed search and ask the employer to supply it. Do not replace the missing source with a colleague's recollection or an undated copy from an internet discussion. If only an archived version is available, label it accordingly and identify the uncertainty it leaves. This allows useful discussion to continue without presenting an incomplete record as if it were the definitive contractual history.

## Job description and job plan

The job description and job plan should tell compatible stories at different levels of detail. The description explains the broad purpose of the appointment, principal responsibilities and organisational relationships. The plan connects the current work to time, objectives, resources and review. A description may remain broadly accurate while the timetable needs revision. Conversely, a changing service can alter the role so substantially that adjusting individual sessions is no longer enough. The reader needs to ask which document has become inaccurate and what decision will correct it.

Daniel's coordination duty illustrates the difference. His job description includes participation in multidisciplinary care, but it does not identify responsibility for arranging the meeting, reviewing referrals beforehand and following unresolved actions. His timetable allocates attendance at the meeting but not the associated work. The manager's reference to multidisciplinary participation therefore answers only part of the question. Daniel can acknowledge that the duty fits the department's purpose while showing that its full delivery is not represented. The disagreement becomes easier to examine once scope and allocation are separated.

A broad duty clause should not be read as a measurement tool. Saying that a doctor will contribute to teaching does not establish how much teaching is required, who the learners are or what clinical work is displaced. Equally, the absence of a task from a weekly grid does not automatically prove that it falls outside the role. The documents and the actual agreement need to be read together. Chapter 6 explains how to construct a job plan that accounts for complete activities rather than treating only visible patient contact as work.

Start a reconciliation by describing a representative cycle. Identify recurring duties, less frequent commitments, associated administration, travel and predictable interruptions. Compare this account with the job description and plan. Mark each difference as an omission, a changed frequency, a changed level of responsibility or a new proposal. These categories help determine the next discussion. An omitted established duty may need accurate recording; an increased frequency may need workload review; a new responsibility may require an explicit agreement about scope, authority and resources.

Be clear about evidence. A work diary can demonstrate that a task occurs and how long it takes under observed conditions. It does not by itself determine the contractual allocation or prove that the task should continue. A clinic letter may evidence clinical work, but confidential patient material should not be circulated merely to support a timetable discussion. Aggregated activity, schedules and non-identifying examples are usually a better starting point. The evidence should illuminate the employment question without creating a separate information-governance problem.

Daniel proposes a short review period with a record of preparation, meeting time and follow-up. He asks colleagues to confirm the coordination responsibilities rather than certify a preferred number of sessions. The service then has options. It may allocate time, redistribute part of the work, provide administrative support or redesign the meeting. Each option has consequences that can be discussed openly. The objective is not necessarily to preserve every existing activity exactly as it is. It is to agree a feasible account of what the service needs and who will deliver it.

Record the outcome in the appropriate place. A change of timetable should appear in the agreed plan. A substantial new responsibility may also need a revised description or appointment record. A temporary arrangement should include its duration, review and what happens if the circumstances persist. Send a short confirmation after the meeting and invite correction of factual errors. Avoid treating silence as a universal substitute for agreement. Where the process requires formal approval, identify that step and ensure the document is not described as agreed before it has been completed.

Once the documents align, use them consistently. The appraisal scope should reflect the actual role, a portfolio entry should explain the doctor's contribution and a development request should acknowledge the available time. Consistency does not mean copying the same paragraph into every system. It means that the systems describe the same professional reality. An accurate job plan cannot do every other process's work, but it prevents the

doctor from repeatedly explaining why the employment record understates responsibilities that colleagues already regard as established.

## Custom practice and informal arrangements

Many NHS services depend on arrangements that began informally. A colleague agrees to cover a session, a doctor develops an educational meeting or a team adopts a useful pattern without immediately revising every document. Informality can make cooperation possible. The risk arises when the arrangement continues, the original participants leave and people disagree about what it now means. The fact that work has been done for years is relevant evidence. It is not a universal rule that repetition creates a permanent entitlement or an unlimited obligation.

Acas explains that a practice can sometimes become an implied contractual term through custom and practice. Its guidance identifies considerations including being generally known, reasonable and sufficiently certain, and warns that a practice cannot override a contradictory written term merely by repetition. Whether a particular arrangement has contractual effect is fact-sensitive. A doctor should therefore avoid announcing that custom and practice conclusively settles a dispute before the documents and history have been examined. The useful starting point is a careful account of what happened and what each party understood.[27]

For Daniel, the original email matters because it described temporary coordination pending review. The years that followed matter too. Was the duty expressly renewed? Did a later job plan recognise it? Was additional time provided elsewhere? Did the doctor periodically request review? Did the employer communicate that it was discretionary or conditional? A complete chronology may support several interpretations. The handbook cannot decide the legal effect of those facts. It can help Daniel preserve them and avoid weakening his account by omitting material that does not immediately support his preferred conclusion.

Separate evidence of performance from evidence of agreement. Meeting minutes show that Daniel chaired meetings. They may not show what was agreed about time or remuneration. A payroll entry shows a payment but may not explain whether it was permanent, discretionary or linked to another duty. An email from a manager may be important, but their authority and the wording remain relevant. Collecting documents by function helps an adviser identify what each establishes. A large bundle without that explanation can make a straightforward issue unnecessarily difficult to assess.

There is also a practical question independent of historical entitlement: what should happen next? A service can acknowledge that the record is poor and still agree a workable future arrangement. Daniel might seek a prospective job-plan correction while reserving a separate question about the earlier period for advice. Another doctor might prefer a planned handover of the duty. These options should be expressed clearly so that resolving one issue does not accidentally appear to settle every other issue. Where rights or past payment are in question, wording and timing may require individual representation.

Temporary agreements are easier to manage when their limits are recorded at the outset. State the reason, duty, expected duration, support, review date and person who will decide continuation. If the arrangement involves extra work, identify what is being changed elsewhere and any separately agreed payment. If circumstances persist beyond the planned review, arrange another decision rather than allowing the date to disappear. A useful record can be brief. The essential feature is that another person can later understand what the parties intended without reconstructing a conversation from memory.

Goodwill should also be distinguished from permanent availability. Helping during an exceptional problem does not by itself define a sustainable service model. If exceptional requests recur, record the pattern and discuss what it reveals about staffing or workflow. The immediate response to a clinical need and the subsequent employment discussion belong to different timescales. The doctor should continue to act professionally while seeking advice on any proposed change in duties. Abruptly withdrawing from established responsibilities without an agreed safe arrangement can create risks that obscure the underlying legitimate concern.

The aim is not to eliminate informal professional cooperation. It is to recognise when an arrangement has become important enough to need a durable record. A service that depends on one person's memory or goodwill has a continuity problem as well as a workload problem. Writing down the responsibility, resources and cover makes it easier for colleagues to support the work and for a successor to inherit it. Proper documentation protects the useful contribution from becoming either invisible labour or an expectation nobody can explain.

## When policies change

A new policy can alter the practical experience of a job even when the underlying national contract has not changed. A different rota process,

study-leave route, travel arrangement or approval system may affect access, workload and timing. Begin by establishing what has actually changed. Obtain the previous and current versions, publication and effective dates, the approving body and any transition guidance. A circulated draft is not necessarily an operative policy. A recently uploaded document may reproduce an older agreement. Date control prevents a discussion being built around the wrong version.

Then identify the nature of the change. Does it change administration, expectations within an existing agreement or a contractual term? Does it apply to all doctors, only certain contracts or new appointments? Does it preserve existing individual arrangements? Acas guidance on contract changes emphasises agreement and consultation. Where a contractual flexibility clause is relied upon, its guidance also stresses reasonable use, consultation and notice; broad wording does not supply unlimited authority. The specific contractual effect should be assessed with appropriate advice rather than inferred solely from the employer's description.[28][29]

Imagine that Daniel's employer introduces a single online approval route for educational activity. The administrative change may be sensible, but it could create a problem if his established teaching commitment is automatically treated as optional leave. He identifies the consequence, attaches the relevant appointment record and asks how the system will distinguish an agreed duty from a new request. His argument does not depend on rejecting the software. It depends on preserving an accurate interpretation of the work when the recording process changes.

Consider the effect on different working patterns. A deadline or meeting time may be convenient for full-time colleagues but difficult for someone whose agreed days differ. A policy that assumes one base may overlook cross-site work. A digital process may require adjustments for accessibility. In Great Britain, reasonable-adjustment duties are addressed through the Equality Act framework described by Acas; Northern Ireland uses its own equality law. The practical enquiry should identify the disadvantage and a workable response, while individual legal questions go to the appropriate adviser.[23]

Consultation is most useful when it describes consequences and alternatives. Instead of saying that a proposal is unacceptable, explain what it would require, which existing agreement is affected and what alternative would achieve the service aim. For example, a proposed earlier start across all sites may create a handover gap elsewhere in a doctor's existing schedule. A response that identifies the gap and proposes a revised sequence helps the

organisation evaluate the change. It also records that the concern is about delivery, rather than an unexplained resistance to anything new.

Ask how existing arrangements will transition. If an allowance, approval or working pattern has a stated end date, establish whether the policy changes the review process or the substantive position. If a doctor has an individual adjustment, confirm how it will be preserved or reviewed. If training is required for a new system, ask when it will be available and what happens before access is functional. Transition details often determine whether a reasonable proposal causes avoidable disruption. They deserve explicit agreement rather than being left to the first person who encounters a problem.

In Northern Ireland, nidirect provides separate guidance on changing employment conditions, including agreement, consultation and obtaining advice where changes are disputed. Its discussion should not be substituted with assumptions about Great Britain procedures or remedies. Whatever the jurisdiction, do not assume that an internal appeal or grievance protects every external deadline. If pay is reduced, duties materially altered, dismissal threatened or a settlement proposed, seek advice promptly. Continuing to work, refusing a change or resigning can each have consequences that general handbook wording cannot safely resolve for an individual.[30]

When the outcome is agreed, obtain a usable record. It should state the decision, effective date, any temporary provisions and which document is amended. Update the employment map and retain the superseded version for the historical record. A meeting that ends with everyone apparently understanding the position can still produce different interpretations later. A short written confirmation gives both sides an opportunity to correct that mismatch while the discussion is recent. It also makes the change comprehensible to a new manager, payroll officer or representative who was not present.

## Resolving uncertainty

The aim of document work is a decision, not an ever-growing archive. Once the relevant material has been gathered, frame the problem in a paragraph. State the current arrangement, the discrepancy, the practical consequence and the resolution sought. For Daniel, the question is that coordination of the weekly meeting is required and recurrent, but the agreed plan appears to omit preparation and follow-up. He asks for confirmation of the role and a review of how the work is accommodated. The historical question about

earlier arrangements is identified separately, with the relevant chronology attached.

Use a discrepancy log sparingly. Each entry should contain the issue, supporting document or evidence, date raised, person responsible, response and next action. Avoid recording every frustrating exchange as if all were equally important. Prioritise matters that affect safe work, pay, contractual commitment or a time-sensitive decision. If an issue is resolved, mark the outcome and close it. A log should reduce the cognitive burden of uncertainty. If it becomes a record of grievance without a decision route, it is no longer doing its intended job.

The first approach can often be informal and specific. A useful formulation is: I may be missing a later agreement; the documents I hold show the following position, while the current instruction appears different. Please confirm the basis of the instruction and whether the attached record needs correction. This wording leaves room for a missing document without conceding the point. It asks for evidence and a decision. It also avoids attributing motives that the doctor cannot establish and that would make an ordinary clarification unnecessarily adversarial.

Prepare for the meeting by identifying the smallest useful outcome. That may be agreement on the facts, an interim safe arrangement, referral to the correct decision-maker or a timetable for review. Not every issue can be resolved by the person attending the first conversation. Ask them to identify the next route rather than accepting that they cannot help as the end of the matter. Record what has been agreed and what remains open. If a decision is deferred, establish the information needed and the date on which it will return for consideration.

Use advice selectively but early enough to matter. A straightforward missing document may be resolved through medical staffing. A disputed contractual interpretation may need a recognised union or employment adviser. An issue involving clinical responsibility or a regulatory investigation may also require a medical defence organisation. These advisers perform different functions, and one may not cover every aspect. Acas provides employment information and conciliation services for Great Britain; the Labour Relations Agency is the corresponding starting point for employment-relations advice in Northern Ireland. Identify jurisdiction before choosing the route.[31]

If formal action becomes necessary, obtain advice on the correct process and deadlines rather than treating every disagreement as a grievance. A job-plan dispute, pay decision, contractual change and disciplinary matter may have distinct routes. State the remedy sought and provide a proportionate

bundle. Avoid sending confidential clinical records or unnecessary information about colleagues. Do not rely on the existence of an ongoing internal conversation to postpone checking legal time limits. The appropriate adviser can explain which action preserves the position while a practical resolution is still being sought.

Daniel's eventual discussion produces a clearer prospective arrangement. The service confirms the coordination duty, agrees to assess the associated work and identifies which administrative tasks can move elsewhere. This is an illustrative outcome, not a prediction that every employer will respond similarly. The unresolved historical issue remains available for separate advice. What has improved is the quality of the decision: the parties now know which facts they share, what each document establishes and what still needs interpretation. That is a meaningful achievement even before every disputed point has been settled.

After a resolution, check implementation once. Has the revised plan reached the system used by the department? Has payroll received any authorised change? Has the person taking over a task understood the agreed boundary? A decision can be correctly recorded yet incompletely implemented. Identify the missing operational step without reopening every settled point. If the implementation differs from the agreement, raise that specific discrepancy and attach the decision record. This final check turns a successful discussion into a change the doctor and service can actually rely on.

Before leaving the chapter, test the method on one uncertainty in your own role. Can you name the governing document set, distinguish fact from inference and state the decision you need in two sentences? Can you identify the person authorised to answer and the point at which individual advice is necessary? If not, begin with the missing information. The employment framework becomes manageable when broad frustration is converted into a precise question supported by the right evidence. The following chapters use that method to examine the work itself, its allocation and the consequences when the agreed plan and service reality diverge.

Chapter 6

# Job planning as the operating agreement

## What a job plan must accomplish

Miriam arrives at her review with a job plan that adds up neatly and a working life that does not. She is a composite Specialty Doctor in Wales, employed under the reformed national contract, with ten contracted sessions. Her timetable contains clinics, ward work, an allowance for on-call activity, professional development and teaching. During the past year she has also become the dependable contact for a second site. The service has added patients, the teaching programme has expanded, and correspondence now follows her into evenings. Nothing in the electronic total indicates that the job has changed.

A representative workload review suggests that the service is asking for approximately twelve sessions of work. Miriam does not begin by demanding that somebody approve the number twelve. She begins with a more useful question: which work does the organisation want her to undertake, and what arrangement will make that work deliverable? An increased contract is one possible answer. So are fewer clinical commitments, redistributed responsibilities, better support or a combination of changes. Her evidence describes a capacity problem; the meeting must turn that evidence into an operating decision.

The job plan is the bridge between the employment documents examined in Chapter 5 and the actual organisation of care. A contract may establish the general framework, while a job description explains the post. The job plan should make those descriptions usable: which duties occur, where they occur, how much time they require, what outcomes are sought and what support makes them possible. The joint NHS Employers and BMA job-planning guide describes a collaborative process linking individual contribution with service planning. It remains useful for that approach, although its older contractual detail must be read against the reader's operative terms. [33]

A timetable alone is insufficient. It can show a clinic on Tuesday without explaining its patient mix, administrative consequences or dependency on a functioning treatment room. An objectives form alone is also insufficient. It

can require improved access without identifying the appointments, staff or authority available. A complete agreement joins the two. The schedule supplies capacity; the objectives explain its intended use; the resource record states the conditions on which delivery depends. The review process tests whether those assumptions remain true.

This has consequences for both parties. The doctor should make a fair account of activity, use agreed time for its stated purpose and raise emerging problems. The manager should clarify priorities and respond when the proposed service exceeds the available capacity. Neither benefits from a document that conceals disagreement behind a signature. A plan that is achievable only because the doctor routinely works unrecorded evenings may appear affordable while carrying an undisclosed dependency. Once the doctor becomes ill, reduces hours or leaves, the dependency becomes visible as a service failure.

Job planning is therefore also a continuity exercise. Imagine the next suitably qualified doctor reading the agreement without access to the current doctor's goodwill or informal relationships. Could they identify the work, the escalation arrangements and the limits? Could a rota coordinator schedule the duties without asking the doctor to fill every gap personally? Could an appraiser understand the employment context without confusing the job plan with a regulatory assessment? If these questions are difficult, improve the description before negotiating its finer arithmetic.

The process should leave space for professional judgement. Patients do not arrive in equal units, and a safe service cannot specify every interruption in advance. The answer is to describe predictable commitments accurately and provide a sensible arrangement for variation. Flexibility works when both sides understand what may change and what must be reviewed. It becomes unreliable when it means that every new request is absorbed indefinitely. Miriam's aim is a plan that colleagues can operate during ordinary weeks and test during difficult ones, with a clear route for deciding what changes when demand exceeds the agreement.

Keep the agreement readable to the people who must implement it. A rota coordinator needs scheduling instructions, a clinical manager needs priorities and dependencies, and the doctor needs an accurate record of commitments. A plan written solely to satisfy a software field may serve none of them well. Use the required system, but attach a clear narrative where its categories cannot explain the work adequately.

## Programmed activities sessions and annualisation

Start with the unit named in the applicable contract. Programmed activity, often shortened to PA, and session are not interchangeable accounting labels simply because both are used in medical employment. The Welsh Specialty Doctor terms updated in October 2024 describe a standard full-time plan of ten sessions, normally four hours each, with separate provisions for out-of-hours work. Northern Ireland's 2021 Specialty Doctor terms use ten programmed activities and the same ordinary four-hour timetable value. State the nation, grade and contractual version beside a calculation so that its assumptions can be checked. [32][34]

For an ordinary daytime activity valued at four hours per unit, the calculation is straightforward: divide recognised hours by four. A recurring two-hour meeting represents half a unit; four hours of clinical work represents one. This is an accounting conversion, not proof that every meeting deserves its requested duration. Establish the necessary work first. Equally, a four-hour label does not establish that a clinic ends within four hours. A timetable should reflect the work being commissioned, including what must happen before and after the visible patient contact.

Keep three quantities separate throughout the discussion: clock hours, contractual units and service outputs. Clock hours describe elapsed work. Contractual units recognise that work under the relevant terms. Outputs describe what the work produces. A clinic containing eight appointments may require a different amount of time from another eight-appointment clinic because the patient groups differ. An evening commitment may attract different contractual recognition from the same duration during ordinary hours. Collapsing all three quantities into one number makes comparisons look simpler while making their meaning less reliable.

Miriam's initial diary records time before converting it. Each entry identifies the activity, start and finish, whether it was already inside a scheduled commitment, and whether it displaced another duty. The entry for a forty-minute telephone discussion about an existing patient is counted once. If it occurred during time already allocated to clinical administration, it helps explain the use of that time rather than adding forty minutes to the weekly total. If it interrupted protected teaching preparation, it records a displacement that the plan must address. Chapter 7 develops the evidence method in detail.

A weekly plan is convenient when the work repeats. It is less satisfactory when activities occur monthly, seasonally or across a long rota cycle. Annualisation can make those patterns visible, but it requires an agreed denominator. Do not start by assuming that every doctor delivers ordinary

scheduled activity during the same number of weeks. Leave, public holidays, study arrangements, rotation, part-time patterns and duties continuing during other absences affect the calculation. A national leave entitlement, a local planning assumption and an actual record of attendance answer different questions.

Consider a purely illustrative daytime teaching programme. The employer wants twenty workshops in a planning year. Each requires one hour of delivery and two hours for preparation, assessment and follow-up. The annual requirement is sixty hours. If the agreed planning model distributes that activity over forty delivery weeks, it represents one and a half hours per delivery week, or 0.375 of a four-hour unit. The result should normally be scheduled in usable blocks, perhaps three hours every fortnight. Nothing in the arithmetic establishes that forty weeks is a national entitlement or that teaching must be divided into small fragments.

The same calculation can be reversed to test a proposal. Suppose sixty hours have been allocated but the programme expands to thirty workshops with unchanged preparation requirements. The requirement becomes ninety hours, leaving a thirty-hour difference. A discussion about efficiency should then identify what would actually reduce that requirement. Reusing a well-designed introduction might save preparation time; assessing more learners might increase follow-up. Merely leaving the annual allocation unchanged does not create efficiency. It leaves either a smaller programme, incomplete work or additional time to be accounted for.

Separate fixed events from average allowances. A monthly committee has dates that must fit the calendar even if its annual total produces a modest weekly average. A doctor cannot attend a two-hour meeting on Wednesday by using thirty minutes on each of four unrelated days. Likewise, averaging on-call activity does not make the demand evenly distributed. The annual view is a budget; the calendar is a feasibility test. Both are needed when sessions are distributed irregularly or several organisations make demands on the same doctor.

Prospective cover needs explicit treatment. If the rota is designed for colleagues to cover planned absence, show how that changes each participant's frequency, activity and available elective capacity. Do not count cover within the rota and then add the same cover again as an independent workload. Conversely, do not calculate a nominal one-in-six commitment from six names if vacancies or known absences produce a materially more frequent actual pattern. The relevant contractual approach controls payment and recognition, while the operational record should show what the service genuinely expects.

Annualisation must not become a debt system in which every cancelled clinic is automatically owed again. Record why a session did not occur and what work was undertaken instead. A hospital cancellation, an agreed professional activity, sickness, annual leave and a doctor's failure to attend are different circumstances. They require different treatment under the applicable arrangements. The useful question is whether the agreed plan was delivered or appropriately varied, not whether a spreadsheet can recover every theoretical slot. Keep prospective capacity planning separate from retrospective attendance investigation.

Before accepting an annual total, ask whether the calculation has counted each hour once, applied the correct time category, made the delivery-week assumption explicit and included the calendar constraints. Retain the arithmetic with the agreement. Another reviewer should be able to reproduce the answer from the same assumptions, and a change in those assumptions should reveal exactly which part of the plan needs reconsideration.

Round only at the agreed stage. Rounding every small activity upwards can inflate a total, while rounding each downwards can erase meaningful work. Retain minutes in the working calculation and show how the final allocation was reached. This makes negotiation more transparent without pretending that the diary measures every task with laboratory precision.

## Direct clinical care

Direct clinical care should describe the complete work of caring for patients rather than only the portion visible to appointment systems. The Welsh contractual definition expressly includes patient-related administration and multidisciplinary meetings about direct patient care. [32] The practical implication is substantial. A service that counts the consultation but not the resulting decision, prescription, referral or communication has measured only part of the work it commissioned. The task may be completed at a desk or by telephone; its connection to care matters more than the room in which it occurs.

Take a clinic lasting four hours on the appointment template. Before it begins, the doctor reviews referrals, investigations and previous decisions. During the clinic, interpretation, examination and discussion generate further actions. Afterwards, results may arrive, letters need checking and other professionals request clarification. Some of that work can sensibly occur within the four-hour block. Some may require a separate period. The job-planning question is not whether every administrative task attracts an

extra allowance, but whether the whole clinical episode is realistically contained in the time already allocated.

Miriam samples several clinics rather than selecting the worst afternoon. She distinguishes preparation, scheduled contact, same-day completion and later follow-up. The sample shows that the existing clinic blocks include most preparation and immediate documentation, but subsequent results and correspondence require a further four hours each week. She checks that the same work has not already been recorded under her general clinical administration allowance. Her proposal is then precise: the present allowance is insufficient by a defined amount under the current patient mix, and the service must decide how to address the difference.

One response might be to reduce the number of booked appointments while retaining the block. Another might be to provide administrative support that genuinely removes non-clinical tasks. A third might be to create a separate clinical administration session. These options have different effects on access, staffing and the doctor's schedule. The most useful evidence allows them to be compared. A statement that the doctor is simply too busy leaves the manager with little basis for choosing; a statement that all correspondence requires medical time ignores opportunities to improve the process.

Patient complexity should be described with care. Avoid presenting complexity as an unchallengeable personal judgement. Identify the features that affect work: multiple decisions, interpreter involvement, cognitive or communication needs, coordination across services, medication reconciliation or substantial records to review. Use anonymised categories rather than identifiable stories in the job-planning record. A case-mix description can explain why a clinic's capacity differs from another without implying that one doctor's patients are uniquely difficult or that another colleague's workload is less valuable.

Multidisciplinary work requires the same discipline. A patient-focused meeting may involve reviewing records beforehand, contributing decisions during the discussion and completing actions afterwards. The meeting's duration captures only its central portion. Agree which preparation is necessary and which actions belong to which professional. If everyone spends an hour reproducing the same summary, redesign may be more useful than multiplying allowances. If the doctor must make a clinical decision based on material that is unavailable until the meeting, apparent efficiency through reduced attendance may instead weaken the quality of care.

Handover belongs in the account of clinical work. A service change can increase handover demand without adding a clinic or ward round. Moving care between sites, extending opening hours or adding an evening doctor can introduce new transitions. Describe the information that must pass, the people involved and the time needed for questions. An electronic list may support the process but does not necessarily replace discussion where decisions or risks remain uncertain. The job plan should fit the actual handover arrangement rather than assuming that it occurs effortlessly between scheduled blocks.

Distinguish predictable emergency work from genuinely unpredictable demand. A regular morning review following an admission period can be scheduled even though the patients' diagnoses are unknown. An unplanned overnight recall has a different pattern. Calling both emergencies does not mean that neither can be anticipated. Examine when the work occurs and how frequently it recurs. If an urgent advice function generates a substantial workload every afternoon, the service may need a scheduled duty rather than an assumption that it will fit between other commitments.

Supervision during clinical care can be particularly difficult to classify. A doctor overseeing another clinician's patient decisions may be providing direct clinical work, whereas a planned educational review has a different purpose. Record the activity accurately before assigning the local category. Do not count the same hour as both a full clinic and an additional hour of supervision merely because both occur together. Instead, show how supervision affects the clinic's capacity and what dedicated time is required outside it. The aim is a credible account of the combined task.

Finally, agree the boundary of follow-up responsibility when the doctor is absent. A well-planned clinic includes arrangements for results, urgent messages and pending decisions that arrive later. If the system sends everything to one doctor's personal queue, reduced hours or leave may expose an unsafe dependence. The remedy may involve team coverage and routing rather than extra individual sessions. Job planning works best when it identifies the service design behind the workload as well as the doctor's share of it.

When a process is redesigned, measure whether work has moved rather than disappeared. Digital dictation might reduce transcription delay while leaving clinical checking unchanged. An electronic referral form might save administrative handling while requiring more medical information. Review the workflow after implementation and compare the whole episode, including follow-up. A technology change should alter the calculation when its actual effect on workload is properly understood.

## Supporting professional activities

Supporting professional activities sustain the quality of the clinical service over time. They include the work of maintaining capability, examining practice and developing the people and systems around care. Their value is often less visible than a completed clinic because the output may be better judgement, a safer process or a competent colleague. That does not make the time optional. The GMC requires doctors to keep knowledge and skills current and to engage with relevant professional development and quality assurance. Those responsibilities need a practicable place in a working life. [3]

Under Schedule 4 paragraph 5 of the October 2024 Welsh Specialty Doctor terms, the job plan includes a minimum of one SPA session designated for job planning and meeting appraisal and revalidation requirements. [32] That minimum is not the complete requirement for every role. The BMA's SAS SPA guidance distinguishes core requirements from further teaching, research and management work, and identifies the Welsh good-practice recommendation of around twenty per cent of a basic full-time commitment. This recommendation should not be presented as an automatic UK-wide entitlement. The applicable contract and agreed duties establish the individual arrangement. [36]

Build the proposal from functions. What professional maintenance does this doctor need for this scope of practice? Which teaching responsibilities are commissioned? What quality work is expected? Is there a defined educational supervision role? Which activities are occasional, and which recur throughout the year? A list that simply says CPD, appraisal and audit can hide considerable variation. A better account explains the work, the intended use of time and the evidence that it happened, without turning every hour of learning into a miniature performance report.

Personal development is not confined to attending courses. Reading, discussion with peers, reviewing a difficult decision, practising a skill and examining a changed guideline may all be useful. The important distinction is between purposeful development and the accumulation of certificates. A doctor planning to extend a procedure may need supervised practice; a doctor maintaining a stable scope may need a different pattern. The job plan should make the proposed activity possible, while the appraisal conversation examines its relevance and learning. Neither process benefits from a universal points quota invented for administrative convenience.

Protected time also requires an operational meaning. If a doctor is listed as doing SPA work but remains the default contact for every routine clinical query, the allocation may exist only on paper. Agree who covers foreseeable

clinical demand and which exceptional circumstances justify interruption. An interrupted session need not automatically become a grievance, but repeated interruption is evidence that the arrangement does not work. Record the displaced activity and agree how it will be recovered or reprioritised. Otherwise, the clinical schedule appears fully delivered while professional maintenance moves into personal time.

Teaching illustrates why delivery time alone is inadequate. A one-hour session may require selecting appropriate material, adapting it to the learners, arranging a suitable setting and responding to questions afterwards. The first delivery may require more preparation than a repeat. Supervising a learner with additional needs can alter the workload further. A proportionate plan recognises these differences. It does not assume that every lecture needs a fixed multiplier, but it also does not assume that knowledge becomes a usable educational session without preparation.

For a formal supervision role, identify learner numbers and expectations. Scheduled meetings, observation, feedback, reports and liaison with an educational organisation can each create work. Daily clinical advice should be considered alongside the clinical timetable, so that it is neither lost nor counted twice. If a supervisor is asked to take an additional learner, the discussion should address capacity before the appointment is treated as complete. A signature accepting the role should be supported by a reasonable prospect of delivering what the learner has been promised.

Quality improvement can also be understated. The visible presentation may follow weeks of defining a problem, obtaining data, testing a change and reviewing the result. A useful allocation states what scale of project is expected and what assistance is available. A small service evaluation conducted with accessible data is different from a project requiring new data collection across several organisations. The doctor can be accountable for agreed contributions without being made solely responsible for every dependency. Chapter 12 returns to how evidence of this work can be retained proportionately.

Research needs its own clarity. Reading research to inform practice is different from recruiting participants, acting as an investigator or managing a study. A broad research label does not establish funding, permissions or the required governance. Where a formal research role is intended, define its commitments and obtain the relevant institutional arrangements before assuming that general SPA time can absorb it. A doctor can have a worthwhile research ambition without an immediate funded role, but aspiration and commissioned activity should be recorded separately.

Less-than-full-time work makes these distinctions particularly important. Some clinical commitments reduce broadly with hours; some professional requirements contain a fixed component. A doctor working six sessions may still need a meaningful appraisal conversation, mandatory training relevant to their role and sufficient development to maintain a safe scope. It is therefore unhelpful to copy a full-time plan and mechanically reduce every supporting activity by forty per cent. Examine the actual duties and requirements, then agree an allocation that is compatible with the reduced working pattern and applicable terms.

Consider a composite doctor, Helen, who reduces her clinical commitment but retains responsibility for supervising two learners. The number of clinics falls, but the agreed supervision duties do not. If the employer expects that role to continue unchanged, the time should be considered on that basis. Alternatively, learner allocation could reduce. The unworkable compromise is to retain the full educational obligation while reducing its time merely because the doctor's overall contract is smaller. That arrangement transfers the cost of the decision to either the supervisor's personal time or the learners' support.

Miriam's proposal separates her professional-maintenance and teaching programme from her cross-site leadership responsibility. This makes the negotiation clearer: reducing leadership duties would not remove the need to maintain clinical capability, and completing mandatory training would not deliver the teaching programme. The resulting SPA record contains a small number of understandable commitments, usable periods in the calendar and an agreed review of interruptions. It treats development as part of maintaining a professional service, while leaving room to test whether particular activities are useful and proportionate.

## Additional responsibilities and external duties

Some responsibilities are substantial enough to require an explicit place beyond the ordinary pattern of clinical care and supporting activity. A doctor may lead a service, coordinate governance across sites, act as an educational lead, manage a workforce programme or hold an agreed external appointment. These duties should be described by what they require, not merely by their title. The Welsh terms distinguish additional NHS responsibilities and agreed external duties from other categories. [32] The practical question is whether the proposed time, authority and organisational support match the responsibility being accepted.

Miriam's second-site work began as occasional advice. It now includes preparing for a monthly operational meeting, reviewing a recurring safety

issue and coordinating actions with another team. Calling her the site lead does not explain whether she is expected to recommend changes, approve them or deliver them. She therefore asks for a short role description before discussing the allocation. It identifies the purpose, reporting relationship, decisions within her remit and the route for matters requiring another person's authority. Her job plan can then attach time to a defined function.

Time should include the work between meetings. A committee membership may involve reading papers, consulting colleagues, preparing an item and following up decisions. A clinical leadership role may require responding to matters that do not wait for the next scheduled meeting. Distinguish recurring demand from exceptional events and describe how priorities will be handled. A nominal session every month is unlikely to explain an ongoing operational remit unless the work has been deliberately limited and another person holds responsibility between those sessions.

Authority needs equal attention. If a doctor is asked to reduce a backlog, can they change booking rules, request data, alter staff deployment or propose additional capacity? If their role is advisory, who receives the advice and decides what to do? If a decision requires funding, who can approve it? A useful job-plan objective might concern producing an options paper and presenting it to the authorised group. It should not quietly turn that advisory task into a guarantee that a whole service outcome will be achieved.

External work should be agreed prospectively wherever practicable. A Royal College role, examining commitment or national advisory appointment may benefit the wider profession and the employer, but the calendar still has to work. Identify the expected meetings, preparation, travel and notice arrangements. Clarify whether the appointment is undertaken within agreed employment time, through professional leave, under a secondment or as a separate commitment. The label external does not answer the funding, cover or accountability questions. Recording the arrangement protects both the clinical service and the external body from incompatible expectations.

Where more than one employer is involved, avoid creating two complete accounts of the same hours. Show which organisation holds each commitment, who pays for it and how the interfaces are managed. One employer may release time that another funds, or the doctor may have separate contracts. The relevant documents should make that visible. A shared diary alone cannot resolve conflicting priorities when both organisations expect attendance at the same time. Named contacts and a

process for resolving clashes are more useful than a general promise to remain flexible.

An additional responsibility should also have an end or review point. Some roles are intended to last for a particular project; others continue until a new appointment is made. State how the role and its associated time will be reconsidered when the project finishes, funding ends or responsibilities change. If clinical activity is to resume, plan the transition rather than assuming immediate return to an old pattern. A doctor who has spent several years in a changed scope may need updated induction, equipment access or supervised refreshment before taking on particular work again.

The same care is needed when a title remains but the resources disappear. A leadership session removed from the timetable does not by itself tell colleagues that the doctor no longer holds the function. The employer should communicate any change in responsibility and identify who will receive outstanding matters. Otherwise, messages and expectations continue while the formal capacity has vanished. Miriam asks that any reduction in her cross-site role be accompanied by a clear handover, an updated contact route and a record of which decisions remain with the receiving manager.

This is also a useful test of recognition. A meaningful role provides an intelligible contribution, sufficient capacity and a fair account of results. A title can be welcome, but it cannot compensate indefinitely for work that remains undefined. Where the organisation values the contribution, the job plan should help make it sustainable and transferable rather than dependent on one doctor's willingness to remain continually available.

## Objectives outcomes and organisational dependencies

An objective should enable a fair conversation about what was sought, what happened and why. It should not be a slogan that acquires a different meaning at the next review. Improve quality, support the department and demonstrate leadership are reasonable aspirations, but they do not establish a testable commitment. Translate them into work that the doctor can undertake, evidence that will illuminate the result and a date for considering progress. Keep the wording proportionate to the task; precision does not require an elaborate management vocabulary.

Begin with the difference between activity, output and outcome. Activity is what someone does, such as reviewing a sample of records. An output is what that work produces, such as an analysis and agreed action plan. An outcome is the subsequent effect, such as fewer incomplete handovers. Each can matter, but they should not be substituted for one another. Attending a meeting does not demonstrate that a process improved. Equally, an outcome

can fail to improve despite competent work if the organisation does not implement the agreed changes.

For example, an objective to reduce delayed clinical correspondence might begin with a baseline review. Miriam and the manager agree which letters are included, how delay is measured and which part of the pathway she can influence. The objective could require her to review the clinical approval process, test an amended workflow and report whether delays change over three months. Administrative staffing, software access and reporting support are named dependencies. This gives the doctor something deliverable without making her personally responsible for every stage between dictation and receipt.

The denominator matters as much as the target. A claim that ninety per cent of letters are completed promptly is meaningless unless the reader knows which letters were counted and when the clock started. A small sample may be appropriate for improvement, but its limits should be stated. An objective should discourage the selective exclusion of difficult cases simply to improve the figure. Where complexity or missing information affects completion, include that context in the review rather than allowing a superficially impressive percentage to conceal the underlying problem.

Use a short objective builder with six connected elements: the purpose, the doctor's contribution, the evidence, the dependencies, the review date and the response if assumptions change. In prose, this might read: Miriam will test a revised results-review process in the agreed clinic cohort, report completion and outstanding-action data at the September governance meeting, and propose changes after a three-month trial. The service manager will provide administrative cover and a monthly data extract. If the data extract is unavailable after the first month, both will review the method and timetable.

That final sentence is not an escape clause. It makes the agreement adaptable and creates an early action point. Without it, a failed dependency may remain unaddressed until the annual review, when the doctor is asked why an objective was not achieved. A timely record allows the organisation to provide an alternative, narrow the objective or accept a delay. The doctor remains responsible for raising the problem and doing the work that remains feasible. The manager remains responsible for decisions and resources within their remit.

Consider a less satisfactory objective: Miriam will reduce readmissions by twenty per cent. It may be motivated by a genuine service concern, but it attributes a complex outcome to one person without establishing case mix, baseline, measurement or authority. The improved objective might concern

reviewing a defined group of readmissions, identifying modifiable themes and testing one agreed change. A subsequent outcome measure can still be monitored. The difference is that the doctor's contribution is now explicit, while the organisation retains responsibility for the wider system in which the outcome occurs.

Clinical outcomes require particular care because the people most in need of care may have the poorest results. A crude target can create pressure to avoid difficult patients or transfer work elsewhere. Include balancing information where a proposed change could have unintended effects. If a service aims to shorten appointments, examine whether follow-up contacts, complaints or incomplete decisions increase. If it aims to reduce admissions, consider whether patients experience delayed access to necessary care. The objective should support better care, not merely a more favourable headline measure.

Development objectives should identify opportunity as well as intention. A doctor can agree to prepare for an observed procedure, complete relevant learning and seek feedback. They cannot create a training list, supervisor or suitable patient opportunities by determination alone. Name those dependencies and the person arranging them. If development is intended to support a future role, distinguish readiness evidence from a promise of appointment. A completed PDP objective can demonstrate progress without conferring a grade, a vacancy or entry to a regulatory register.

Miriam also has a leadership objective, but it is limited to her actual authority. She will bring a cross-site escalation proposal to the divisional group, consult specified teams and revise the document in response to feedback. The divisional manager will decide whether to adopt it and arrange implementation resources. The evidence includes the proposal, consultation record and decision. This avoids measuring Miriam's performance by whether a committee chooses to fund a change. It also avoids allowing the committee's decision to erase the quality of her contribution.

Keep the number of objectives manageable. A long list can obscure priorities and create commitments that no one remembers commissioning. Separate continuing duties from a small number of particular developments for the coming year. A recurring clinic belongs in the schedule; a project to redesign its referral process may belong among the objectives. Mandatory responsibilities should not disappear simply because they are not selected as improvement objectives, but listing every normal duty as a target adds administration without necessarily improving accountability.

At review, record the result in language that preserves the distinction between effort, delivery and context. Completed as agreed, completed with a revised timetable, partly completed because of a documented dependency, and not completed despite available support are materially different findings. Discuss what evidence supports each conclusion. This record becomes useful for subsequent job planning, appraisal and, where relevant, pay progression. It should be sufficiently clear that those later processes do not have to reconstruct the circumstances from competing recollections.

## On call premium time travel and cross site work

On-call arrangements contain several different quantities: how often the doctor is available, how much work occurs, when it occurs, how intense it becomes and what recovery is needed afterwards. A rota frequency cannot describe all of them. One-in-six availability may produce a relatively quiet advisory commitment in one service and repeated overnight attendance in another. Begin by describing the actual duty, including the sites covered, expected response, access to information and backup. Only then can its workload and contractual recognition be calculated sensibly.

Do not confuse payment for availability with recognition of work undertaken. A doctor may receive an on-call supplement while also having clinical work from that duty reflected in the job plan. The applicable terms explain the relationship. For a diary, separate telephone advice, record review, travel and attendance, and identify work already included in scheduled periods. Record consecutive interruptions as accurately as practicable. A succession of short calls may have modest aggregate duration but a substantial effect on sleep and next-day functioning; both facts are relevant to planning.

The out-of-hours boundary is not uniform across the UK. The Welsh Specialty Doctor terms updated in 2024 and the Scottish 2022 Specialty Doctor terms place the ordinary weekday boundary at 19:00. Northern Ireland's published 2021 Specialty Doctor terms use 21:00. Saturdays, Sundays and relevant holidays also require the applicable treatment. [32][35][34] A calculation imported from another nation can therefore misvalue the same evening work. Older contracts must also be identified separately rather than assumed to follow a newer agreement because the doctor shares its rota.

For England, use the English Specialty Doctor or Specialist terms for the contract actually held, available through the NHS Employers links in the BMA's national contract directory. Record the weekday boundary, weekend treatment and applicable recognition mechanism from that document before

converting an evening rota. A Welsh amendment does not establish the English position. [38]

Northern Ireland's 2021 Schedule 8 illustrates why the mechanism matters. For qualifying predictable out-of-hours work it provides, by agreement, a shorter timetable value for that PA or a reduction elsewhere; it also addresses enhanced payment and work only partly outside ordinary hours. [34] Do not apply every mechanism simultaneously. Write down which arrangement has been agreed, show the relevant portion of time and check the resulting schedule. The clock may show four hours while the contractual recognition follows a different calculation; both quantities should remain visible.

For Miriam's Welsh illustration, the chosen planning arrangement recognises an average of three hours of qualifying out-of-hours emergency work as one session. This is an average, not a prediction that she will work exactly three hours in every week. A longer representative rota record is used because the initial four-week diary does not capture her full on-call cycle. The calculation includes work actually associated with the duty and excludes time already counted in scheduled daytime activity. Her availability supplement remains a separate payroll matter, outside the session total. [32]

The next-day timetable must be examined alongside the payment calculation. If a doctor is repeatedly unable to obtain adequate rest, a larger allowance alone does not make the service safe. The GMC's concerns guidance requires doctors to act on risks arising from inadequate systems or resources through appropriate routes. [37] An urgent fatigue or patient-safety issue needs an immediate operational response. The job-plan review then addresses recurrence, such as alternative cover, a different rota pattern or changes to next-day commitments. Recording the problem solely as unpaid time misses its clinical significance.

Cross-site work introduces another form of invisible demand. An appointment at one location may be followed by a meeting at another, but a timetable that places them back to back assumes instantaneous travel. Record the ordinary journey between work locations, the likely variation and any necessary preparation on arrival. Distinguish employment travel-time recognition from mileage reimbursement and tax treatment: those are separate questions. The proposed schedule must first be physically possible, whatever the eventual expenses decision. A payment for mileage cannot create time to complete the journey.

Group activities geographically where that improves the service. A cross-site leadership meeting and clinic on the same day may reduce repeated

travel, provided their timing and clinical dependencies fit. Remote attendance may remove a journey where the task can be done effectively and confidentiality is maintained. It may be unsuitable where direct examination, observation or local engagement is necessary. The decision should turn on the work rather than an assumption that remote participation is always equivalent or that physical attendance is always more valuable.

Travel also competes with recovery. A long drive after demanding on-call work creates a different risk from a routine daytime transfer. Agree the operational response to fatigue, including who can arrange alternative cover or transport where required. Do not turn a personal judgement about fitness to drive into an expectation that the doctor must independently solve every staffing consequence. The doctor should communicate the concern promptly; the service needs a practicable response. These arrangements belong in the wider rota and safety system as well as the individual's plan.

Finally, test the whole pattern over time. Look for clusters of nights, weekends, travel and early starts rather than judging each duty separately. Include commitments to other employers where relevant. A week that appears tolerable in isolation may recur within a demanding sequence. Conversely, an unusually busy week may not represent the normal pattern but still expose a need for contingency. The completed plan should describe expected work, the evidence used to estimate it and the trigger for a review when the actual pattern changes materially.

Test response expectations against geography as well. A doctor cannot promise immediate attendance at two distant sites simultaneously. The arrangement needs a first response at each location, a way to assess urgency and a named escalation route when demands conflict. These are service-design requirements, not questions that a session calculation can settle. If the employer changes the sites covered, revisit those arrangements even when the number of doctors on the rota and the nominal frequency remain unchanged.

## The job planning meeting

Preparation should make the meeting easier to decide, not harder to read. Send a concise summary of the current agreement, the main discrepancy, the evidence and the proposed options. Keep detailed diary material available as an appendix or supporting record. The manager should be able to identify the decision before encountering every data point. Miriam's opening page states that her current ten-session plan cannot contain the documented work, identifies the recurring additional demand and offers two ways to restore a workable arrangement.

Agree an agenda that moves from facts to choices. First confirm the contract and present duties. Then examine the evidence of workload and any difference in interpretation. Next consider service priorities, the proposed allocation and supporting resources. Finish with objectives, scheduling, review and outstanding matters. This order reduces the risk of spending most of the meeting arguing about a preferred PA figure before either party has agreed what work the figure is intended to represent. It also makes misunderstandings easier to locate.

Use neutral, specific language. Miriam might say: my diary shows that results and correspondence regularly continue beyond the allocated period; I would like us to agree whether that work remains mine and, if so, how it will be accommodated. That wording does not surrender the concern. It directs attention to the decision. If the manager disputes the diary, ask which entries or assumptions are disputed and what further evidence would resolve the question. A general claim that everyone is busy does not answer a specific capacity calculation.

Listen for a different problem beneath an objection. A manager who says there is no funding may mean that increasing the contract is unavailable, not that the work is unnecessary. The next discussion can therefore examine what should stop, move or change. A doctor who rejects an additional session may be protecting health or another commitment, not denying the service need. The plan should make those constraints explicit so that a workable alternative can be considered. Neither party should have to conceal a legitimate constraint behind an argument about efficiency.

Where the proposed timetable contains competing priorities, test an ordinary difficult day. What happens if the clinic overruns before a leadership meeting? Who deals with an urgent result during SPA time? What happens when another site requests attendance? Practical examples often reveal ambiguity that a table conceals. Agree the usual priority, the person who can authorise a change and the treatment of displaced work. A general expectation of flexibility is more credible when the organisation has considered these foreseeable conflicts.

Close with an accurate record. State what has been agreed, what remains disputed, which evidence is still required and who will take each next action. Include dates. If only part of the plan is agreed, do not let a generic completion status suggest that every element has been accepted. The electronic system should reflect the substance of the discussion; it should not determine that substance by forcing a premature sign-off. Obtain advice if the system's options make it difficult to record the actual position.

Miriam's meeting ends with agreement on clinical administration and teaching, but not yet on the cross-site role. The record identifies the manager who will clarify that remit and the date for reconvening. The current disagreement is therefore contained and visible. Miriam leaves knowing what she should continue to deliver, what is being reconsidered and when a decision is expected. That is a more useful interim outcome than either a resentful signature or an undocumented promise to sort things out later.

Before leaving, read the summary back in ordinary language. We have agreed these clinical commitments, these supporting activities and these resources; we have not yet agreed the leadership remit; this person will provide the missing information by this date. The exercise can expose different interpretations while both parties are present. It is especially useful where several managers have contributed to the discussion or a decision requires approval elsewhere. If an authorised decision-maker is absent, distinguish a recommendation from approval. A draft allocation should not be presented to colleagues as operationally confirmed until the necessary agreement and implementation arrangements are in place.

## Review mediation and appeal

A job plan should be reviewed when its assumptions change, not simply when a calendar reminder appears. The Welsh framework provides an annual review and interim review for significant changes. [32] In practice, useful triggers include a new clinic, sustained growth in follow-up work, a changed rota, additional supervision, a health-related adjustment or a substantial leadership appointment. The request should explain what has changed and what decision is needed. It need not wait until the doctor can prove that every element of the existing plan has failed.

An interim review can be narrow. If a teaching programme doubles in size, the immediate question may concern that programme and its effect on the schedule. Reopening every aspect of the job can make a modest correction unnecessarily difficult. Equally, several apparently small changes may together justify a complete review. Use the evidence to determine the scale. A temporary arrangement should have a clear duration, because an unreviewed temporary duty can become a permanent expectation without the associated resources ever being agreed.

When discussion does not resolve the issue, identify the contractual route promptly. Mediation and appeal are specific processes, distinct from an informal conversation and potentially from a grievance. The applicable terms control who receives the request, the timescale, evidence requirements and effect of the outcome. Do not import consultant

procedures into an SAS dispute merely because a general webpage discusses both. A union or employment adviser can help establish the correct route and preserve deadlines while local resolution continues.

Wales provides a concrete example. Under Schedule 5 of the October 2024 Specialty Doctor terms, the written mediation referral is due within ten working days of the disagreement arising. A subsequent formal appeal must be lodged within ten working days of receiving the relevant decision. The schedule also addresses the status of disputed elements pending resolution. [32] These are Welsh contractual provisions, not a universal UK timetable. A doctor should record the event that starts each deadline and obtain advice immediately if its date or meaning is uncertain.

The case for mediation should be compact enough to understand. State the disputed element, the relevant contractual provision, the evidence, the proposed resolution and the consequences of the alternatives. Attach the current plan and the disputed proposal with clear dates. Include agreed facts as well as disagreements. A mediator should not have to infer the issue from a year of email exchanges. Where the disagreement concerns workload, the explanation should show how the time calculation was made and what happens operationally if the proposed allocation is insufficient.

Continue to separate immediate safety management from the employment dispute. A pending appeal does not make it appropriate to leave an urgent clinical risk unaddressed, nor does an urgent response necessarily settle the permanent contractual question. Record any temporary cover or variation accurately, seek advice about its status and use the appropriate safety reporting route when needed. The aim is to protect care while preserving a clear account of what has and has not been agreed. Avoid unilateral assumptions about either entitlement or obligation in a contested situation.

After resolution, check implementation. Does the revised timetable match the decision? Have payroll changes, responsibilities and cover arrangements been updated where required? Have colleagues been told about changes that affect them? A successful appeal or agreement is incomplete if the old workload continues informally. Retain the outcome and arrange a practical review after the new pattern has operated. Miriam's objective is not simply to win an argument about sessions. It is to establish a sustainable service arrangement that remains intelligible after the disagreement has ended.

Retain a short chronology rather than an indiscriminate archive. It should show the existing agreement, the date the issue was raised, substantive responses, the point of disagreement and each formal step. Preserve original

documents securely and avoid patient information in employment submissions unless specifically necessary and appropriately handled. An accurate chronology helps an adviser distinguish a continuing discussion from a missed procedural deadline. It also helps a new manager understand an unresolved issue without relying entirely on the account of either participant.

## Worked complete job plan

Return to Miriam, the composite Welsh Specialty Doctor. This illustration uses the reformed Welsh terms updated in October 2024, a ten-session substantive commitment and ordinary daytime sessions valued at four hours. It is a planning example, not a model entitlement. On-call work is calculated separately at the agreed out-of-hours conversion described earlier. Actual dates, leave, rest and prospective-cover arrangements require the employer's calendar and rota; the following annual view concerns scheduled daytime delivery only.

The agreed allocation is six sessions of scheduled direct clinical care, two sessions of SPA, one session for additional cross-site leadership responsibilities and one session recognising average unpredictable on-call work. The total is ten. Scheduled daytime activity therefore occupies nine sessions, or thirty-six hours. The on-call allowance represents an average of three actual out-of-hours working hours in the chosen illustration. Thirty-nine actual working hours are therefore recognised as ten sessions; ten multiplied by four would give the wrong clock-hour total for this mixed pattern.

The six daytime clinical sessions comprise two clinic sessions, two ward sessions, one patient-focused MDT and follow-up session, and one clinical administration session. These total twenty-four hours. The two SPA sessions provide eight hours for the agreed professional-maintenance, teaching and quality programme. The leadership session provides four hours, including its agreed cross-site travel. The categories describe allocations, not a requirement to perform every component in an indivisible four-hour block. The calendar shows how the blocks and any smaller activities fit.

An illustrative daytime week places a clinic and clinical administration on Monday; ward work and the MDT on Tuesday; one SPA session and leadership on Wednesday; the second clinic and second ward session on Thursday; and the remaining SPA session on Friday morning. Friday afternoon is not silently available for another routine clinic. It is outside this daytime schedule, with the remaining contractual recognition allocated to

on-call work occurring elsewhere in the rota. Actual breaks, start times and travel are recorded in the detailed calendar.

For a deliberately simplified annual capacity illustration, the employer and doctor model forty weeks in which that complete daytime pattern is delivered. Six clinical sessions multiplied by forty gives 240 clinical sessions, or 960 hours. Two SPA sessions multiplied by forty gives eighty sessions, or 320 hours. One leadership session multiplied by forty gives forty sessions, or 160 hours. The scheduled daytime total is 360 sessions and 1,440 hours. Forty delivery weeks is an illustrative assumption, not a statement of leave entitlement. The on-call rota has its own annual calendar and is not multiplied by forty here.

The original workload evidence suggested twelve sessions because necessary additional correspondence consumed four ordinary hours and the expanded cross-site and teaching demand consumed another four. The agreed ten-session solution does not erase those eight hours. Clinic booking is revised to contain the documented follow-up requirement within the clinical allocation, part of the expanded teaching programme is reassigned, and the cross-site remit is narrowed to specified deliverables. The manager records who takes the displaced work and confirms that the receiving arrangements are operational before the revised pattern begins.

The objectives concern a defined correspondence improvement trial, delivery of the agreed teaching programme and a cross-site escalation proposal. Their resource record names administrative support, data access, teaching facilities and the manager responsible for decisions beyond Miriam's authority. An early review checks whether the changes actually remove the excess demand; the annual review remains scheduled. The completed agreement therefore contains a timetable, reproducible arithmetic, responsibilities, resources and a means of correction. Its success will be judged by whether the service and doctor can work to it in practice.

The October-to-September plan is reviewed in December. Site A hosts clinical work; Wednesday leadership includes Site B. The clinical manager reviews the plan and the divisional manager sponsors leadership. A six-person calendar records on-call dates and cover. The allocation is linked to those able to organise it.

Chapter 7

# Making hidden work visible

## Why work becomes invisible

Daniel's clinic finishes at five. The activity report records the appointments attended, the patients who did not attend and the next available slots. On that account, the afternoon has ended. Daniel leaves the hospital, eats with his family and later spends ninety minutes checking investigations, completing correspondence and resolving two medication queries. None of this surprises him. He has worked like this for years. What surprises him is the assertion, during a review of clinic capacity, that there is unused time immediately after the last booked appointment.

Daniel is the composite experienced Specialty Doctor introduced earlier. For this example he works in England on the 2021 Specialty Doctor contract. His problem is not established by the fact that he works at home, nor solved by calling everything overtime. The first question is what necessary work the clinic generates, how much of it is already provided for and what remains outside that provision. Location and timing are evidence about delivery. They do not, by themselves, establish the correct contractual allocation.

Work becomes invisible when the organisation measures an encounter but not its completion. The clinic is a convenient counting unit; the result reviewed three days later is less convenient. A procedure appears in a theatre system; preparing a patient whose procedure is subsequently cancelled may disappear from the performance report. A service records the meeting but overlooks the decisions prepared beforehand and implemented afterwards. The measurement system may be behaving exactly as designed. Its limitation emerges when the resulting activity count is treated as a complete description of professional work.

Professional habits can reinforce the omission. An experienced doctor may answer queries quickly, coordinate colleagues without a formal meeting or prevent a problem before anyone records an incident. Competence makes work look effortless. Loyalty then makes it difficult to say that the arrangement needs changing. The doctor worries that documenting minutes will appear ungenerous. The manager sees a service that has continued to function and reasonably asks what has changed. Both need a record that explains how the service functions, including the personal time on which its apparent efficiency depends in its usual daily use.

Role growth produces another form of invisibility. A request to advise on one difficult referral becomes a daily referral service. Temporary responsibility for teaching becomes an annual programme. An absent colleague's task remains with the person who covered it because nobody explicitly transfers it back. No single addition seems large enough to trigger a new job plan. Taken together, they can consume the space previously available for development, reflection or recovery. The important comparison is between the agreed role and the present work, not between this week and last week alone.

The purpose of measurement is therefore to reconstruct the work faithfully. It should show useful activity, duplication, waiting, avoidable friction and genuinely uncertain demand. Some findings will support additional time. Others will support fewer appointments, different staffing, better systems or removal of tasks that add little value. An honest diary can reveal that a familiar arrangement is inefficient as well as under-resourced. That possibility strengthens its credibility. A record designed only to prove a predetermined claim is less useful to either party and harder to verify independently.

Start with a limited question: what work is missing from the present description, and what decision would better evidence enable? Daniel does not need to monitor every minute of his career. He needs a representative account of the clinical work generated by his clinics, a comparison with existing provision and an achievable proposal for closing the gap.

Working fewer contracted sessions does not remove the need for this analysis. A less-than-full-time doctor may still have fixed commitments, such as a required meeting or preparation for appraisal, that do not reduce neatly in proportion to clinical sessions. Conversely, some activity will reduce with the number of clinics delivered. Separate fixed, variable and occasional work before comparing colleagues. A smaller contract should not be treated as a compressed full-time job, and a proportional calculation should not replace examination of the actual duties.

## Clinical administration

The phrase clinical administration can make skilled clinical work sound like clerical overhead. Reviewing an abnormal result requires interpretation, context and a decision. A referral may need prioritisation or clarification. A prescription query can require reconciliation across several records. A letter communicates a clinical conclusion and distributes responsibilities. These tasks are part of delivering care even when no patient is physically present. GMC standards require appropriate records and effective continuity of care;

the work needed to meet those responsibilities must be considered when a service is designed.[3]

Begin by separating tasks that require a doctor's judgement from tasks that could be completed by appropriately trained administrative or clinical colleagues. The distinction is practical rather than hierarchical. Copying an appointment date into a letter is different from deciding how urgently a patient needs review. A well-designed pathway may allow another professional to undertake some clinical decisions within their competence and agreed responsibilities. That does not mean a manager can assume the task has disappeared. The proposed recipient needs time, training, access and a clear route for uncertainty.

For Daniel, the first sample covers four weeks in which he undertakes eight comparable clinics. He records the time spent preparing records, seeing patients and completing clinical work afterwards. Within the follow-up category he distinguishes correspondence, results, referrals, prescribing and patient or professional advice. He does not copy patient names into the diary. A short description such as results review and action is enough. If corroboration is needed, aggregate task counts can be obtained through the employer's authorised system rather than creating a private parallel clinical database.

The follow-up periods after his eight clinics are sixty, seventy-five, ninety, one hundred and five, eighty, one hundred, ninety-five and one hundred and fifteen minutes. Their total is seven hundred and twenty minutes: twelve hours, or an average of ninety minutes per clinic. The spread matters. The evidence does not say that every clinic requires exactly ninety minutes. It says that these eight clinics generated a mean of ninety minutes, with observed values between one hour and nearly two hours. The team should examine whether the sample reflects the expected case mix.

Suppose the current plan already provides thirty minutes per clinic for this work. The sampled difference is then sixty minutes per clinic, not ninety. Across eight clinics the unprovided component is eight hours. This subtraction is essential. A proposal that claims all twelve hours as additional would double count four hours already recognised. Equally, an assertion that the existing thirty minutes must be sufficient because it appears in the job plan would confuse the agreement with evidence of present demand. Both figures belong in the discussion.

Count activity at the level that answers the question. A hundred electronic messages do not necessarily represent a hundred decisions. Several may relate to one issue; one message may require a lengthy review. Record a manageable combination of task volume and time. If the system generates

avoidable duplication, distinguish that from necessary clinical work. The current service still has to deal safely with duplicated messages, but the proposed remedy may be to repair routing rather than permanently fund the duplication.

Preparation and delayed follow-up also need a boundary. A result reviewed this week may arise from a clinic several weeks earlier. Assigning every minute to a specific clinic is often unnecessary. A rolling sample can measure the total weekly burden against the normal clinic programme, provided the opening and closing backlog are recorded. Otherwise a week spent clearing old work may look like ordinary demand, while a week in which work accumulates may falsely look efficient. A short backlog measure helps interpret the time record in that short sample.

Quality must remain visible alongside speed. Finishing correspondence rapidly is not a success if actions remain ambiguous or responsibility for results is uncertain. Daniel can sample whether letters were completed within the service's agreed timescale and whether required follow-up was allocated. He should not invent a national turnaround standard. The relevant measure may be a local pathway requirement or a clinically justified target agreed by the team. Explain what the measure means and who agreed it before using it to support a capacity decision.

The resulting proposal can be specific: protect a further hour of clinical follow-up for each comparable clinic during a defined trial, reduce the appointment template correspondingly if total contracted time remains unchanged, and review completion times and backlog after the trial. Another option is to redesign the workflow and measure again. Neither option assumes that Daniel should simply become faster. Both make the hidden task a visible part of the service that generates it.

Include the practical conditions for remote completion if that remains part of the agreed arrangement. Daniel needs authorised access, an appropriate device, a private place to work and clarity about when messages are expected to be answered. Working from home should be an agreed method of delivering a defined commitment, rather than an unspoken overflow mechanism. If technical access repeatedly fails, record that lost working time separately from clinical judgement. The remedy may be reliable access or protected on-site provision, not an expectation that the doctor repeatedly attempts the task during personal time.

## Unpredictable and interrupted work

Some work cannot be scheduled as individual appointments, but unpredictability is not the same as immeasurability. A doctor may not know

when an urgent review will be requested, yet the service may reliably generate several such requests each day. The useful distinction is between uncertainty about the timing of an event and uncertainty about its overall volume. A job plan can make provision for a recurring category of unpredictable demand without pretending to forecast every call.

Interruptions need particular care because a simple elapsed-time diary can mislead. Daniel may spend forty minutes on correspondence between two and three, with twenty minutes diverted to urgent advice. Recording an hour of correspondence and twenty minutes of advice would claim eighty minutes within a sixty-minute period. Instead, record the primary activity and the interruption separately, with a total that reconciles to the actual hour. If he must repeat work because his concentration was broken, record the observable repeated task rather than adding an arbitrary recovery multiplier.

Not every interruption is unwelcome. Timely advice may prevent an unnecessary admission or support a colleague working within a supervised role. The question is whether that function has a place in the service model. A referral-advice role distributed informally through personal familiarity can become concentrated on one approachable doctor. Colleagues may be unaware of its total volume. Counting the category allows a discussion about a designated advice session, rota or shared inbox, including who covers it when the usual doctor is unavailable.

Use representative sampling agreed before the outcome is known. A four-week sample may be adequate for a regular clinic programme but inadequate for an infrequent on-call rota or seasonal service. Record why the period was chosen and what it excludes. A week with a vacancy, unusual outbreak or major system failure should not be deleted simply because it is exceptional. Label it and show both the ordinary pattern and the exceptional burden. Managers need to know whether the proposed plan addresses routine delivery, foreseeable peaks or temporary disruption.

For brief advice, a tally in broad time bands can be more sustainable than timing each conversation. The bands are an approximation, so report them as such. For longer episodes, start and finish times may be realistic. A count of twelve brief calls, three intermediate reviews and one prolonged escalation is more informative than a retrospective statement that the afternoon was constantly interrupted. It also invites examination of which requests needed Daniel specifically and which could safely have followed another pathway.

Record displaced work as well as interruption time. If an urgent review consumes a planned teaching session, the teaching has not been delivered merely because the doctor remained busy. The diary should show which

activity took place and which agreed commitment was deferred. This is particularly important when progression objectives later depend on the cancelled work. The same hour cannot simultaneously satisfy an urgent clinical commitment and an educational objective requiring undivided preparation. A service that routinely substitutes one for the other needs to revise its expectations.

Do not convert a workload diary into an incident log. Immediate concerns about deteriorating patients, unsafe staffing or failed escalation require the clinical and organisational response appropriate at the time. The later diary can record a non-identifying category and the existence of a separate incident report. It should not become the only place a safety concern is documented. GMC guidance requires doctors to respond when safety is compromised; assembling evidence for next month's job-planning meeting is not a substitute for action today.[37]

When presenting variable demand, show a central estimate and a practical range. Explain the consequence of providing only the average when several urgent tasks arrive together. A buffer might require protected flexibility, access to another clinician or a threshold for reducing routine activity. It should not be a vague request for unlimited spare time. The strongest proposal identifies what the service will do when demand exceeds the planned allowance, who decides and how deferred work will be recovered.

This approach makes uncertainty discussable. It does not eliminate pressure, but it prevents unpredictable work from being treated as work that somehow requires no capacity.

There is also work that never starts because another demand displaces it. A diary of completed tasks alone can understate this problem. Alongside time, record a small number of outstanding commitments and why they remain outstanding. Avoid listing every aspiration. Concentrate on agreed work with a real deadline or consequence: an overdue review, a cancelled supervision meeting or a report needed for a service decision. This allows the discussion to distinguish productive flexibility from persistent failure to provide capacity for an agreed function.

## Travel and cross site responsibility

A timetable can contain two apparently compatible commitments that cannot both be reached on time. A clinic ends at one site at noon and a meeting begins at another at noon. The problem is visible once the journey is included, but frequently the schedule records destinations without the transition between them. Cross-site work must be considered as an actual

sequence undertaken by a person, including handover, departure, travel, parking, access and preparation for the next duty.

First distinguish ordinary commuting from travel required in the course of work. The relevant contract, designated base arrangements and employer travel policy determine the treatment of time and expenses. A change of base, travel between employers and a journey from home to an emergency call-out can raise different questions. Do not assume that reimbursement of mileage settles whether time is recognised, or that recognition of time establishes entitlement to a particular expense. Keep the two questions separate and seek a written answer where the arrangement is unclear.

For a worked planning example, suppose Daniel is required to move between two hospital sites during a normal working day. The expected road journey is twenty-five minutes, and leaving one clinical area and reaching the next reliably adds fifteen minutes. The transition therefore needs about forty minutes in the operational timetable. This is an illustrative measurement, not a national travel allowance. If the timetable contains only the road journey, it still asks him to perform an impossible transition. If congestion frequently changes the journey, the range belongs in the evidence.

Remote attendance can reduce travel but should be tested against the task. A governance meeting may work well online. A clinical review requiring examination cannot be replaced merely because the video link is convenient. An educational discussion may be remote while a trainee's observed procedure requires presence. The decision should ask what the activity requires, not assume that all cross-site work can be compressed into telephone availability. Reliable technology, appropriate privacy and access to records are part of the proposed arrangement.

Travel time should not automatically be filled with another duty. A doctor driving between hospitals cannot also be treated as fully available to conduct complex clinical consultations. Even as a passenger, a confidential discussion may be inappropriate or the connection unreliable. If a manager proposes remote work during travel, test whether the conditions allow safe, effective performance. The fact that some calls have previously been taken on the move is evidence of a coping arrangement, not proof that it is a sound service design.

Cross-site responsibility also extends beyond journeys. A doctor may be asked to maintain clinical oversight of two units while physically present in one. Record the agreed response expectations, the local staff available, the route for urgent help and the work generated by remote oversight. A nominal forty-minute journey does not establish that a doctor can leave a clinic

immediately, arrive at the other site and meet every urgent need. Capacity and availability must be examined together. Chapter 9 develops the safety implications when expected cover exceeds those arrangements.

A practical improvement may involve clustering duties by site, changing meeting times, creating a local first-response arrangement or sharing cross-site work. It may also require fewer simultaneous responsibilities. Present the proposed sequence as a realistic day, with transition time shown explicitly. Where a new service spans organisations, identify who authorises travel and who owns the resulting work. The aim is a timetable that can be delivered safely in the world as it is, with the contract and expenses arrangements documented alongside it.

## Teaching governance and leadership

Teaching is often measured by the hour in which learners are in the room. That hour may depend on reviewing material, adapting examples, arranging cases, preparing accessible resources and providing feedback afterwards. The amount varies with the task. Repeating a familiar tutorial differs from creating a new course. Rather than applying a universal preparation ratio, describe the programme, the audience and the work needed to deliver it to the agreed standard. A sample of actual preparation can support a more credible estimate.

The BMA's SAS guidance recognises a broad range of supporting activities, including development, teaching, audit, appraisal preparation and service-management contributions. Its examples help identify omitted work; they should not be read as a guarantee that every doctor receives the same allocation for every activity. The agreed duties, relevant national terms and task requirements remain the basis for the individual plan.[36] A minimum allocation for professional maintenance should not silently become the assumed resource for an expanding portfolio of additional roles.

Clinical supervision during patient care and a formal educational-supervisor role need separate descriptions. Advice delivered while reviewing a patient may be part of the clinical encounter. Scheduled progress meetings, reports, assessment review and liaison about a learner's difficulties generate additional work. Do not count the same clinical hour twice, but do not treat the supervisor title as cost-free. Specify the number and type of learners, the required outputs and the arrangements when someone needs more support than the normal allocation allows.

Governance work has a similar sequence. A meeting may require reading incident themes, checking a pathway, discussing evidence with colleagues, drafting an action and reviewing whether it was implemented. Attendance

alone gives little indication of the contribution. A doctor who takes responsibility for an action should identify what completing it entails and whether authority, data and administrative support exist. Otherwise a meeting minute can create an obligation without creating the conditions for its delivery.

Consider a further composite, Leena, a Specialist in an English service. She is asked to lead a quarterly review of prescribing quality and deliver a teaching programme in response. The timetable shows four one-hour meetings a year. Her proposed ledger adds the actual work categories: defining the question, reviewing authorised aggregate data, discussing findings, preparing teaching and checking subsequent performance. She does not claim sole credit for the team's improvement. She identifies her own contribution and the support needed from pharmacy, administration and clinical colleagues.

The right discussion is then about the function, not whether four meetings deserve an arbitrary number of PAs. Could data preparation be undertaken by an analyst? Can existing teaching be adapted? Who implements changes? Which parts require Leena's clinical judgement? The resource estimate may fall when tasks are distributed sensibly, or rise when previously omitted responsibilities become clear. Either outcome is preferable to a title that allows everyone to assume someone else is doing the work.

Leadership includes work between formal meetings: resolving rota problems, preparing recruitment, coordinating a service change, reviewing risks and explaining decisions. Record purpose and output rather than every email. A series of short conversations might belong to one recruitment episode or one service-design decision. This grouping makes the account readable and avoids portraying ordinary collegial contact as a separate paid event each time. The unit of analysis is the responsibility being discharged, supported by a reasonable estimate of its demands.

Time and authority should be tested together. Allocating a session to a lead role will not solve the problem if the doctor cannot access the necessary information or obtain decisions from those responsible. Conversely, granting a title or committee seat does not provide time to perform the function. A role description should identify its boundaries, expected outputs, escalation route and review point. If additional work is accepted temporarily, record how it will end, transfer or become part of a revised agreement.

This evidence also improves succession. A successor should inherit a described role, not discover its true demands through evenings spent

catching up. A realistic account respects the work already undertaken and makes it possible for someone else to perform it sustainably.

Annual programmes need particular attention because their workload is uneven. Recruitment may involve intense shortlisting and interviews during one month, followed by little activity in another. A course may require substantial redevelopment before its first delivery and less work when repeated. Record these patterns as annual commitments with delivery windows. A weekly average can support the overall allocation, but the timetable still needs room for the period when the work actually occurs. An average alone cannot put a doctor in two meetings at once.

## On call work and recovery

An on-call rota describes when a doctor is available. It does not, on its own, measure the work performed during that availability or the effect on the following day. Frequency, intensity, predictable duties and actual unpredictable activity need separate accounts. A one-in-eight rota can be more demanding than another one-in-six rota if the former covers a larger or less supported service. Comparing the ratios alone answers only part of the question.

BMA guidance distinguishes the availability supplement from the programmed activity needed for work arising on call. It recommends an agreed reference period that captures telephone work, associated records and necessary return journeys, and attention to adequate rest. The precise calculation and supplement depend on the applicable contract and pattern.[39] Do not assume that receiving an availability payment means all clinical work undertaken during that period has already been accounted for. Equally, do not count an entire non-resident period as continuous active work without examining the relevant working-time and contractual rules.

A useful on-call record begins with the rota commitment and adds actual episodes. For each episode, record approximate start and finish, remote or resident activity, associated travel where relevant and necessary documentation. Keep separate the scheduled ward round that everyone knows will occur and the unscheduled deterioration that might occur. If predictable work routinely fills much of the period, the service should examine whether the arrangement is accurately described. The name on the rota cannot make an intensive working pattern less demanding.

Suppose an illustrative doctor undertakes four comparable non-resident nights in a reference period. Active work totals one, three, two and six hours. The mean is three hours, but the final night is important rather than inconvenient. It may reveal exceptional demand, an unsupported site or a

recurring concentration of admissions. Examine what happened before deciding whether twelve hours divided by four is a sufficient planning description. Averages help allocate resources; they should not conceal a foreseeable unsafe peak.

Recovery requires its own operational agreement. Record when work ended, whether sleep was materially interrupted and what was scheduled afterwards. A doctor who finishes prolonged clinical work in the early morning should know whom to contact about fitness for the next duty and how the service will arrange cover. This should not depend on negotiating from scratch while exhausted. The relevant working-time requirements, contractual protections and local rest arrangements need to be translated into a usable process for the actual rota.

The diary should avoid asserting a medical diagnosis of fatigue or estimating sleep from the duration of every phone call. Describe what is known: work episodes, available rest intervals and the doctor's concern about safe performance. An occupational-health assessment may be appropriate where health or repeated difficulty affects the arrangement. Immediate patient-safety decisions remain distinct from later negotiations about payment. Paying for additional work does not restore lost sleep or make simultaneous duties compatible.

Prospective cover also changes the real frequency of work. If the nominal rota assumes a full team but the working arrangement regularly covers colleagues' planned absence, count the duties actually expected across a representative cycle. Keep agreed prospective cover separate from unexpected short-term absence and a persistent vacancy. These situations may require different contractual treatment and different service responses. A diary provides the factual starting point; it does not authorise an employer to rely indefinitely on exceptional cover without a fair review.

The proposal should therefore describe three linked requirements: recognition of the availability commitment, allocation for the work expected and a workable recovery and escalation arrangement. Reducing any of those to a single rota fraction loses information the doctor and employer need to plan safely.

## From diary to defensible proposal

Raw data rarely persuades on its own. A manager presented with forty pages of timestamps may struggle to see the decision required. Convert the diary into a short account of the current agreement, the observed work, the difference and the available options. Retain the underlying sample so the summary can be checked. The aim is neither a courtroom bundle nor a

polished assertion without supporting evidence. It is a proportionate explanation that another person can follow and test for the stated decision.

The hidden-work ledger can use six fields: activity, why it is required, current provision, observed demand, consequence of the gap and proposed response. Add the sampling period and any major exclusions at the top. For Daniel's clinic follow-up, the relevant row would identify the work generated by eight clinics, four hours already allowed, twelve hours observed and eight hours currently displaced beyond the allowance. The proposed response might be protected time or a redesigned workflow, with a named review date.

Annualisation needs an explicit denominator. Suppose, purely for this planning example, the service expects Daniel to deliver eighty comparable clinics in the coming year after accounting for his actual pattern of leave and other duties. At the observed mean, those clinics would generate one hundred and twenty hours of follow-up. The existing half-hour allowance would provide forty hours. The estimated gap is eighty hours. This is a projection from a limited sample, not a universal annual entitlement, and it should be reviewed against changes in case mix and workflow.

Do not automatically multiply every weekly number by fifty-two, nor assume a standard number of working weeks without checking the arrangement. Some duties occur throughout the year with cover; others occur only when the individual is present. Annual leave, study leave, public holidays and planned service cancellations must be handled consistently. A calculation that removes leave from one side but not the other can create a misleading gap. Ask a colleague or manager to check the arithmetic and assumptions before the meeting.

Time recorded in minutes should remain in minutes until the relevant contractual conversion is agreed. A four-hour weekday example is not a licence to apply that value to every PA, session or out-of-hours period across the UK. Chapter 6 explains the contractual framework. Here the key discipline is to separate observation from conversion: this work took a stated time; the relevant agreement determines how that time is represented in the plan. Keeping those steps distinct makes disagreement easier to locate.

Offer more than one practical response where appropriate. Daniel might protect follow-up time by reducing appointments, maintain activity by agreeing additional capacity, or redesign tasks with clinical and administrative colleagues. Each option has consequences. A larger paid commitment may be unacceptable to him or unsafe in combination with other work. Reducing appointments may affect access and require a service-level decision. Delegation may require investment before it produces

savings. A defensible proposal acknowledges these constraints rather than presenting extra payment as the only possible outcome.

Agree what would count as improvement during a trial. Useful measures might include work completed within the agreed pathway, backlog, cancellations, time spent outside the scheduled allocation and the experience of the staff receiving redistributed tasks. More appointments alone would not show that the arrangement is working. Nor would a reduced diary total if unfinished work has simply moved to another person. Review the whole process sufficiently to detect those substitutions.

End the discussion with a record of what is agreed, what remains disputed and who will do what next. If the evidence itself is challenged, agree a further sample with a clear question and endpoint. Repeatedly requesting more measurement without identifying the remaining uncertainty is not a meaningful review process.

After a change, reconcile the new plan with the old one. Identify which duties have been added, removed, shortened, transferred or rescheduled, and obtain agreement from those receiving transferred work. This prevents an apparent solution in which new time is allocated while all previous activity is still expected. The revised document should show a deliverable total, not a collection of individually reasonable promises that cannot coexist. Keep the previous version so the reason for the change remains understandable at the next review.

## Keeping the record proportionate

A workload diary should reduce ambiguity, not create a second job. Choose the least burdensome method that can answer the agreed question. A few categories and a short daily entry may be enough. Existing calendar records, clinic totals and authorised system reports can corroborate the account. The purpose is to understand a work pattern, not to produce continuous surveillance of professional life or a permanent record of every interruption.

Keep clinical information where it belongs. The ledger does not need names, dates of birth, hospital numbers, detailed histories or copied messages. Even an apparently anonymous description can identify someone if it contains an unusual combination of facts. Use broad categories and aggregate counts. If a specific incident must be investigated, refer to the authorised reporting system through the appropriate process. A personal workload file is not the place to retain an alternative version of the clinical record.

Use employer-approved storage when the material concerns work, and clarify who will see it. Do not place workplace data into a personal

application simply because it offers convenient charts. Check the organisation's information-governance requirements before using a new tool. This is especially important where the tool synchronises with external services or processes text automatically. A simple secure spreadsheet can be entirely adequate; sophistication in software does not compensate for uncertainty about confidentiality or purpose.

The record should be fair to colleagues. It can state that a task arrived through a particular pathway without judging another professional's motives. Describe missing information, repeated requests or delayed access in observable terms. If a disagreement concerns conduct, it requires its own fair process. A diary assembled for job planning should not quietly become a dossier of accusations. Keeping these purposes separate protects both the usefulness of the evidence and the working relationships needed to improve the service.

Set a retention and review point. Once the agreed summary and relevant employment record are established, retain supporting material only as required by employer policy, the purpose of the exercise and any advice about an ongoing dispute. Avoid accumulating years of unnecessary detailed logs. For future reviews, a short repeat sample may be more informative than a vast archive describing a service that has changed.

Allow correction. If Daniel discovers that a recorded interval included a break or duplicated another entry, he should amend it transparently and recalculate the summary. Credibility does not depend on a flawless first attempt. It depends on a method that is understandable and responsive to error. Where estimates were entered retrospectively, label them as estimates rather than giving them the appearance of precise observation. A candid range is more defensible than an exact-looking number produced from uncertain recollection. The aim is enough accuracy for a fair decision, with the limitations visible to everyone considering it.

Stop when evidence is sufficient. Daniel must establish the care-completion mismatch and agree a deliverable arrangement. A successful ledger becomes unnecessary as the job plan describes reality. Hidden work is then recognised.

Chapter 8

# Pay progression additional work and disagreement

## Pay scales and progression points

A pay scale is a map of salary points, not a complete account of how an individual reaches them. Before asking whether the salary is correct, identify the grade, nation, contractual version, recognised experience, current point and progression date. Then distinguish an increase to the value of the scale from movement along it. A national pay award can change the amount attached to the same point. Progression changes the point at which the doctor is paid. The two may occur close together without being the same decision.

This distinction explains why a payslip alone is an unreliable guide. An increase might include an award, back pay, an extra duty or a change to an allowance. A reduction in take-home pay might reflect a tax-code change rather than a reduction in gross entitlement. Compare the employer's statement of basic salary and contracted commitment with the appropriate dated scale, then reconcile separate additions and deductions. If something does not match, ask payroll to identify the calculation and medical staffing to confirm the underlying employment information.

Current salary figures are best checked against a national pay circular or the employer's authoritative implementation of it. Save the version and effective date used. A scale found through a search engine may belong to an earlier year, another nation or a different contract. The same grade name does not guarantee the same figure or progression structure. This chapter therefore explains the mechanisms and evidence rather than reproducing salary tables that may be out of date before a reader reaches a particular decision.

Recognised experience also needs a documentary basis. The date a doctor joined the current employer may differ from the date used for pay progression. Relevant previous work, transfer arrangements or an agreed starting point may affect the record. Do not assume that all previous medical employment counts identically for every contractual purpose. Ask which service was recognised, under which provision and with what resulting date. An appointment error is easier to correct while the recruitment

correspondence and decision-makers remain available than several years later.

The 2021 reforms introduced a closed-gateway approach to progression, whereas older contracts have their own incremental and threshold arrangements. The BMA's guidance distinguishes these structures, including the higher threshold on the reformed Specialty Doctor scale. Its practical message is that progression requirements should be clear in advance and supported by objective evidence.[40] An anniversary is therefore a prompt to establish the process, not proof that a salary increase must occur every year on every contract.

A doctor at the top of a scale may still develop substantially. Greater capability can support a broader role, an application, a regrading process where available or a separately agreed responsibility. It does not create another pay point above the published scale. Conversely, reaching a higher point within a Specialty Doctor scale does not confer the Specialist employment grade or entry on the Specialist Register. Chapters 14 to 18 examine those distinct progression routes. This chapter concerns decisions within the existing employment relationship.

Before the next review, make a small pay record containing the appointment terms, confirmation of recognised service, latest progression decision, relevant salary circular and current payslip. Add the next expected review date and the person responsible for arranging it. This should fit into the wider portfolio rather than become a separate archive. Its value is simple: when a question arises, the doctor can show what was agreed, what was implemented and which part requires explanation.

Many payroll queries are administrative and can be resolved quickly. Identify the error before treating it as a performance dispute.

Where a correction is agreed, ask for the period affected and the resulting calculation. A lump sum described only as arrears is difficult to check. The explanation should distinguish the corrected salary, any related payment that changes with it and deductions applied through payroll. Retain that explanation with the decision so a later query does not require reconstructing the original error.

## Closed gateway progression

Closed gateway normally requires positive employer confirmation that the criteria have been met before movement to a higher-paying point. Do not assume that ordinary administrative silence means approval. However, specific absence and employer-delay protections can require progression without a completed review; apply those provisions separately.[41] The

review draws on existing professional and employment processes while remaining a distinct decision. Appraisal participation does not replace all contractual conditions, and a job-plan disagreement should not casually be recast as appraisal non-engagement.

Use the operative contract and review form together. For a concrete national example, Northern Ireland's 2021 Specialty Doctor terms require satisfactory annual participation in job planning and appraisal, with appraisal outcomes aligned with organisational standards and objectives; reasonable effort towards time and service commitments; achievement of job-plan objectives or reasonable effort where circumstances prevent it; work towards agreed supporting changes; and completion of mandatory training or reasonable effort where prevented. They also specify the absence of a formal capability process and of a live disciplinary sanction, with defined limits on those terms.[34] These are contractual conditions for that framework, not a new GMC assessment imposed on every SAS doctor.

The conditions need to be read as separate questions. Participating in a job-plan review is different from agreeing every proposed alteration. Meeting an objective is different from demonstrating reasonable effort when a dependency failed. Mandatory training completion is different from attendance at an optional course. A review that reduces these questions to an overall impression of whether a doctor has been cooperative is too imprecise. Ask which criterion is being considered and what evidence would establish it.

The words formal process and sanction also matter. Northern Ireland's published progression guidance excludes an investigation or informal stage from the formal-capability condition, and excludes an investigation, counselling and ill-health absence warnings from the disciplinary-sanction condition.[41] A complaint received by the organisation is therefore not automatically the contractual event described by those terms. Where a manager relies on a process, establish its documented status, applicable policy and outcome. Do not ask a pay review to determine the merits of an unresolved clinical allegation through implication.

England's relevant 2021 terms, current implementation guidance and the doctor's own agreement must be used for an English review. Wales and Scotland require their own texts and amendments. The BMA's overview specifically identifies a difference in the application of the additional-work and private-practice provisions in Wales.[40] This is why a generic checklist circulated between colleagues needs checking against its intended contract. A familiar-looking form may omit a condition, add an inapplicable one or use an obsolete threshold structure.

A higher-threshold review requires attention beyond the ordinary conditions. Northern Ireland's Specialty Doctor framework, for example, asks for evidence of increasing independent decision-making and contribution to a wider role, alongside standard progression requirements.[34] The evidence should show the relevant responsibility and contribution. It should not be manufactured by acquiring a title shortly before the meeting. A sustained contribution to service improvement or teaching may be stronger than nominal membership of several committees, provided it meets the applicable test.

Preparation should begin early enough to address a genuine gap. As a planning habit, look ahead several months, obtain the current review form and compare it with the evidence already available. This suggested timetable is not a universal contractual notice period. The operative policy may specify one, and it takes precedence. Confirm who convenes the meeting, who makes the decision, who submits the outcome and how it reaches payroll. A successful conversation without the required administrative confirmation may still leave the salary unchanged.

If a criterion is not met, the response should identify the precise gap, relevant circumstances and required action. That might involve completing training, obtaining an appraisal that was cancelled, documenting previously unrecorded evidence or addressing an established formal process. The nature of the gap determines the next step. Do not assume that every adverse outcome requires another full year of the same activity, or that every delay will be automatically backdated. Those consequences must come from the relevant terms and decision.

Finally, separate three dates: the scheduled review, the date progression would take effect and any deadline to challenge a decision. They are not interchangeable. A doctor who keeps attending informal meetings may still need to protect a formal appeal position. A doctor who has already met the criteria may still need to establish when the employer will implement them. Clear dates make a closed gateway a manageable process rather than an unexpected obstacle discovered on a payslip.

## Specialist grade additional expectations

The Specialist employment grade carries a senior contribution that extends beyond simply spending longer in clinical practice. Some contracts make particular evidence of improvement and education part of pay progression. These conditions must be distinguished from appointment requirements and from GMC supporting-information requirements. The fact that a contractual review asks for a full audit cycle does not make a full annual audit a

universal revalidation rule. Different processes can draw on the same project while applying different tests.

Northern Ireland's 2021 Specialist terms provide a clear example. They specify a full audit cycle concerning the doctor's own clinical practice, agreed with the clinical director through job planning, with identified learning addressed. They also require evidence of delivering learning through relevant supervisor training and/or at least one relevant educational lecture or workshop. The terms additionally address anonymous colleague and patient multisource feedback since appointment or last progression, with demonstrated learning from the results.[42] Readers on another nation's contract should compare its exact requirements, including the period over which evidence is required.

A full audit cycle needs a question, a relevant standard, measurement, a response and further measurement sufficient to evaluate the change. This is a practical explanation of the method, not a promise that any project labelled audit will satisfy a particular review. Choose a question that is meaningful, feasible and close enough to the doctor's practice for their contribution to be clear. An elaborate organisation-wide project may create dependence on data and authority that the doctor does not control.

Continuing Leena's English case from Chapter 7 as an illustration of audit method, her chosen topic concerns whether a defined group of clinic letters clearly allocates responsibility for follow-up. This does not apply Northern Ireland's terms to her employment. She agrees the question and standard, uses an authorised sample, discusses the findings with colleagues, introduces a revised template and reviews a subsequent sample. The portfolio records her role, the findings, the response and what remained uncertain. It does not need patient-identifiable letters or a claim that improved documentation has proved a reduction in clinical harm.

The educational component should also show a completed contribution. A session on the revised approach could include its purpose, audience, materials, feedback and a short reflection on what learners found difficult. Supervisor training may be relevant where that route is allowed, but a certificate should be described accurately. Completing training does not automatically establish appointment as a recognised supervisor, and delivering a lecture does not establish all capabilities of an educational-supervisor role. Record what happened without inflating its significance.

Feedback evidence needs time to produce useful learning. Plan the method with the appropriate organisational process and allow sufficient opportunity for colleagues and patients, where applicable, to respond. Do not select only favourable feedback or equate a good average score with a

complete account of practice. A small concern about communication may matter even when most responses are positive. The useful portfolio entry explains what was learned, what changed and how the doctor knows the response was delivered.

These activities can be combined intelligently. Leena's audit informs teaching, and subsequent feedback may help evaluate the communication change. They remain distinct evidential functions even if they arise from one programme. Identify which requirement each item addresses, where it only provides partial support and which additional information is needed. Reusing evidence is sensible; claiming that one attractive project satisfies every condition without analysis is not.

The job plan should make delivery possible. Agree the subject, data access, teaching opportunity, time and review period before the progression date approaches. If the organisation wants these contributions, it should know how they are supported. The doctor should know what they are expected to produce. This creates a clearer relationship between senior responsibility, practical opportunity and the evidence considered at review.

## Evidence before the review

The strongest evidence pack is usually a short index supported by existing records. Start with the criteria in the applicable form and place one or two suitable references beside each. The reviewer should be able to identify what happened, when it happened and why it is relevant without reading an entire career portfolio. Chapter 12 develops the wider evidence architecture. For progression, selection and explanation are more useful than volume.

The job plan provides the agreed commitments, objectives and resources. The latest review establishes what changed. Appraisal outputs can confirm participation and relevant development, while the training record shows completion or outstanding requirements. For a threshold or Specialist-specific criterion, include the relevant contribution, project or feedback record. Keep any confidential appraisal material proportionate to the employment decision; sharing every reflective detail is not automatically necessary merely because appraisal is one source of evidence.

Build a simple chronology. Record when the objective was agreed, when work began, what support was requested, what was delivered and when any obstacle was raised. Where an objective depends on another team, identify that dependency without assigning blame. An email requesting access on a specific date is stronger evidence than a retrospective claim that access was always difficult. A meeting note confirming cancellation of protected time is more useful than an unsupported impression that study was never allowed.

Daniel's composite progression case illustrates the method. On his English 2021 contract, he agreed to complete a service review using an approved data extract and to attend a relevant course. The job-plan record identified access to data and protected time as necessary support. During the year, the extract was not provided and two approved study periods were cancelled for service cover. At the progression review, the incomplete objective is cited as a reason to withhold progression. Daniel needs to distinguish his own effort from the organisational conditions that prevented completion.

His evidence should contain the original objective, the agreed dependencies, dated requests, responses, work completed meanwhile and the review correspondence. It should also disclose any relevant omission on his part. If he delayed asking for data until the final month, that matters. If the employer offered a workable alternative that he did not consider, that also matters. A fair account is not weakened by acknowledging facts that require explanation. It is weakened when a selective account collapses under a straightforward question.

He can summarise the position in one paragraph: the agreed objective required specified data and time; he requested both on stated dates; neither was available as planned; he completed the preparatory work that remained feasible; and he asks that the progression decision apply the relevant contractual treatment of circumstances beyond his control. The supporting documents can then be numbered. This is more effective than sending a long narrative of frustration in which the criterion and requested remedy are difficult to identify.

Check the status of each item. A draft report is not a completed report. Attendance is not delivery. A proposed audit is not a closed cycle. An appraisal booked for next month is not one already undertaken. Where evidence is pending, state the expected date and what it will establish. This allows the reviewer to decide whether the condition is met, whether an agreed exception applies or whether a further step is required. Accuracy protects both the decision and the doctor's credibility.

Before submitting, ask whether another reader could reach the same account from the documents. Remove duplication, repair unclear dates and explain abbreviations. Use neutral filenames and keep the material in an authorised location. A colleague or representative may help identify where the argument relies on an assumption. They do not need to endorse every conclusion to improve the pack. The aim is a reviewable record that supports the right decision under the correct contract.

After the meeting, obtain the written outcome and confirm its transmission to the team implementing pay. Save the final version, not merely the form you submitted. If progression is approved, check the effective date and resulting salary. Completion of the evidential process and completion of the payroll process are both necessary for the decision to have its intended effect.

The checklist can be used at three points. Early in the review period, identify the requirements and gaps; midway, examine whether agreed opportunities are actually occurring; before the decision, confirm completion and unresolved constraints. These are suggested preparation points rather than extra formal reviews imposed by the handbook. Their purpose is to avoid discovering a missing requirement when it can no longer be addressed. Record each gap as an action with an owner and date, rather than simply marking the criterion red.

For Daniel, this would have made the dependency failure visible before the final meeting. The interim entry might read: data requested, preparatory method completed, extract outstanding, manager to confirm an alternative by the agreed date. That short record preserves both his activity and the organisation's next action. It also leaves space to revise the objective openly if the original method is no longer realistic.

## When the employer has not provided opportunity

An unmet objective can have several explanations. The doctor may not have undertaken agreed work, may need further development, may have faced an unforeseen barrier or may have been asked to achieve something that was never feasible with the resources provided. These possibilities should not be collapsed into one conclusion about commitment. The purpose of examining dependencies is to identify what happened and apply the relevant criterion fairly, not to excuse every incomplete task.

The BMA's progression guidance states that doctors should not be prevented from crossing a threshold because employer or senior-colleague action or inaction prevented the required opportunity.[40] Northern Ireland's official progression guidance expressly provides that employer action or inaction preventing satisfaction of a criterion should not prevent movement to the next point.[41] These protections require careful application to the facts. They do not mean that a doctor can ignore an objective and later attribute its non-completion to a generally pressured service.

Daniel should therefore show reasonable action within his control. Did he ask for the data when it was needed? Did he alert the manager that the objective was at risk? Could a smaller authorised project have addressed the

same purpose? Was the course cancelled by the employer, and was an alternative offered? Did his clinical cover actually occupy the agreed study time? The answers distinguish a documented dependency failure from a claim that cannot be assessed. Where the evidence is mixed, the review should address the mixture explicitly.

The organisation's response should also be examined. A manager may have faced legitimate service pressure when cancelling time. That explains the decision but does not make its consequences disappear. If the objective remained unchanged, the doctor was left carrying an expectation after the means of delivery had been removed. The practical remedy is to assess the past progression decision under the relevant terms and separately agree a feasible future objective. Rewriting the future does not necessarily correct an adverse past decision.

Lack of opportunity can be less visible than cancelled leave. A doctor may be required to demonstrate teaching but repeatedly excluded from the programme; to lead an improvement but denied access to the committee; or to show experience of a procedure without receiving the agreed supervised sessions. Record the opportunity requested, its relevance to the criterion and the response. Avoid assuming motive. The evidence may support a straightforward development correction, a contractual challenge or, where facts indicate unequal treatment, a separate equality concern requiring advice.

For a doctor working less than full time or returning from absence, examine the actual period and opportunities available. Fixed professional requirements remain, but raw full-time activity totals may be an inappropriate comparison. Northern Ireland's guidance provides for an early review before planned long-term paid absence, such as maternity, adoption or shared parental leave, where reasonably practicable. If review cannot occur before the progression date, progression should be applied automatically in the doctor's absence, except where a disciplinary sanction is in place when progression is due. Where a doctor moves employer shortly before progression, the new employer should review within three months of employment. If its action or inaction prevents that review, the guidance requires automatic progression from the due date. These are specific protections with defined circumstances, not a general rule that every delayed review produces automatic progression.[41]

Do not allow reasonable adjustments to become an unexplained obstacle to progression. If an agreed adjustment changes working arrangements, objectives and evidence expectations should be considered coherently. The doctor should not be encouraged to abandon a necessary adjustment merely

to produce a more familiar-looking portfolio. Where disability, health or family-related leave interacts with an adverse decision, obtain advice on the relevant national law and contractual provisions. A progression form may not capture every duty owed by the employer.

The outcome should say whether the criterion is satisfied, whether the contractual protection applies, what remains to be done and what support will be provided. If the employer disagrees with Daniel's account, ask for the disputed facts and reasons in writing. That gives informal resolution, mediation or appeal something concrete to examine. An assertion that everyone is under pressure does not settle whether this particular decision is contractually justified.

## Additional programmed activity and extra contractual work

Additional work needs an agreement that describes more than the payment. Identify the task, expected time, duration, place, clinical support, responsibility for follow-up and the mechanism for ending or reviewing it. A recurring extra clinic, a one-off bank shift and temporary cover for a senior role may be governed differently. The label extra should start an inquiry, not conclude it. Work can be additional to the timetable while still being consequential to existing clinical duties, as Daniel's follow-up example showed.

An additional programmed activity is a contractual mechanism where the applicable terms provide for it. In Northern Ireland's 2021 Specialty Doctor terms, prospectively agreed additional PAs are remunerated, and the annual rate is ten per cent of full-time basic salary for each additional PA. The terms also provide a minimum three-month termination notice for these additional PAs.[34] That is a specific contractual example, not a universal rate or notice period for all extra work. A locally negotiated waiting-list session may use a different agreed arrangement.

For clarity, consider a hypothetical full-time basic salary of £80,000 solely to illustrate that NI formula. One agreed annual additional PA would be £8,000 a year before deductions; two would be £16,000. These figures are not a current SAS salary scale or an hourly locum recommendation. The example demonstrates why basic salary, number of additional PAs and duration of the arrangement must be established before checking payroll. Part-year delivery, annualisation and out-of-hours provisions require the relevant calculation rather than casual division by the number of clinics.

Temporary work should have a real review point. If the arrangement is intended to cover a vacancy for three months, identify who reviews it before that period ends. If it becomes the normal service model, reconsider the substantive job plan and staffing rather than relying on repeated informal extensions. The doctor may be willing to help briefly but unable to maintain the commitment indefinitely. A clear endpoint supports planning for both parties and reduces the risk of disagreement about what was promised.

Acting responsibilities require particular precision. Taking an occasional decision in the absence of a colleague is not necessarily the same as a formal acting appointment. If the doctor is asked to cover a defined higher role, establish the duties, authority, supervision where needed, appointment process and applicable payment provision. Do not infer a Specialist appointment from a request to cover a clinic normally led by one. The grade question, the work question and the remuneration question need their own documentary answers.

For bank, locum or waiting-list work, obtain the offer through an authorised route. Clarify whether payment is hourly, sessional or for a specified list, and what happens if the list overruns or is cancelled. Establish responsibility for results and complications after the immediate session. A rate that appears attractive may cover more work than the advertised hours suggest. The service needs safe continuity, and the doctor needs to know whether later work is included, separately scheduled or transferred through an agreed pathway.

Pensionability is a separate question from whether work is paid through payroll. It depends on the scheme, type of employment and nature of the payment. NHSBSA guidance on the 2015 Scheme clarifies that additional hours for part-time staff up to whole-time equivalent are pensionable at the standard rate, following the retrospective regulatory change made in April 2025.[43] This does not justify treating every extra payment as pensionable, or every activity beyond a standard full-time commitment in the same way. Scotland and Northern Ireland have their own administrators and rules to consult.

Ask payroll to identify the pensionable component and, where necessary, obtain confirmation from the relevant pension administrator. Keep gross pay, pensionable pay, pension contributions and tax distinct. A higher gross payment can affect tax and pension-tax calculations without creating an equivalent increase in benefits. Chapter 21 explains the mechanisms in detail. At this stage, the practical requirement is to understand what is being offered before relying on an assumed net amount or retirement effect.

Capacity remains a clinical question as well as a financial one. Consider all employers, on-call commitments, travel and recovery. A free evening in one rota may follow an intensive day or precede another duty. Payment does not make fatigue safe, and a willingness to undertake extra work does not remove working-time or professional responsibilities. The doctor and employer should know the whole pattern sufficiently to assess the proposal. A decision to decline further discretionary work can be reasonable even when the service needs it urgently.

Finally, distinguish the freedom to negotiate an extra arrangement from obligations already contained in the contract. Private-practice provisions, spare professional capacity and agreed additional work can interact in specific terms. Obtain contract-specific advice before assuming an unrestricted right either to require work or to refuse it. A sound agreement records the relevant provision, the task and its limits, leaving neither party dependent on assumptions about what extra usually means.

An additional-work decision sheet can be completed before accepting the offer. Describe the proposed work in one sentence, then record the total expected time including preparation and follow-up. Identify the contractual mechanism, payment basis, approval route and pension question. Add the effect on the existing week and the date the arrangement ends or is reviewed. If any essential field remains unknown, ask the person authorised to clarify it. This is a way of making the offer understandable, not a new bureaucratic approval process.

Consider a Saturday list offered as a fixed session. The doctor should know whether pre-list assessment, reporting and later results are included, whether supporting staff remain available if it overruns, and who manages patients needing admission. These questions affect safety and the real amount of work. They should be resolved prospectively wherever possible. A disagreement after the list is completed is harder to settle because each party may have formed a different understanding of the same short message.

## Mediation appeal and grievance

The first step in a disagreement is to identify the decision. Is the problem an incorrect payment, refusal of progression, disagreement about a job plan, treatment by a colleague or an immediate safety concern? Different routes exist because these questions require different remedies. A payroll correction may not need mediation. A contractual progression appeal should not be allowed to disappear into an informal conversation about morale. A safety concern requires action even while the employment position is being clarified.

For SAS job-plan and progression disputes, use the mediation or facilitation and appeal provisions in the applicable national terms. The BMA describes these as routes for unresolved disagreement about a plan or a progression decision, with contract-specific arrangements for the panel and process.[44] Northern Ireland's official progression guidance directs such disputes to Schedule 5 of its terms.[41] The terminology itself can differ: do not assume that a process called facilitation locally has precisely the same steps as one described elsewhere as mediation.

Obtain the written decision, reasons, date of communication and relevant procedure immediately. Identify the notice required to start the next stage and the person to whom it must be sent. A deadline may run from notification rather than from the date the doctor finishes gathering evidence. If advice is needed, seek it promptly and ask how to preserve the position while the full submission is prepared. An informal promise to discuss matters later should not be assumed to extend a formal deadline.

Mediation can be useful where the parties disagree about interpretation, resources or the practical shape of a job plan. Prepare the points already agreed, the remaining issues, the evidence and possible resolutions. The mediator needs a question that can be addressed. Daniel might ask whether his documented efforts and the employer's failure to provide agreed support have been properly considered under the progression criteria. That is more manageable than asking the meeting to resolve every frustration accumulated during his employment.

An appeal should address the grounds permitted by the relevant procedure. Those may concern the decision, evidence or application of the terms, but the exact scope must be checked. Organise the submission around the contested finding and requested remedy. Include the chronology and relevant documents, explain why they matter and avoid personal criticism that adds no evidence. A representative can help distinguish a strong contractual point from an understandable but less relevant account of how the process felt.

A grievance may be appropriate for matters that the contractual route does not resolve, such as alleged unfair treatment or conduct. More than one process may be relevant, but duplication can create confusion. Ask how the procedures interact and whether an issue should be addressed first in one forum. Do not assume that submitting a grievance preserves a contractual appeal or an external legal claim. Keep a separate record of each route, its purpose, owner and deadline.

A useful route selector is a short question sequence. What outcome is sought: correction of a calculation, reversal of a progression decision,

agreement of future duties or investigation of treatment? Which document gives the relevant decision-maker authority? What procedure challenges that decision? What separate safety or legal issue remains? Write the answers before drafting a lengthy submission. If one account contains several distinct requests, label them clearly so a response to the easiest question does not leave the most consequential issue unresolved.

External legal time limits require particular care. Acas guidance checked on 12 September 2026 states that most Great Britain tribunal claims then have a limit of three months less one day, with the limit for most claims increasing to six months less one day where the relevant time limit starts on or after 1 October 2026. It also explains that an internal grievance or appeal does not itself change the tribunal limit; timely Acas notification can affect the clock through early conciliation.[45] Different claims and circumstances require individual calculation, so obtain advice rather than applying those headline periods mechanically.

Northern Ireland uses its own employment legislation and tribunal arrangements, with the Labour Relations Agency as the relevant early-conciliation body. The Great Britain change must not be assumed to apply there. The Northern Ireland government explains the notification and early-conciliation route through its employment-tribunal guidance.[46] This jurisdictional distinction matters even when the underlying workplace problem looks identical. A doctor moving between nations should not reuse a deadline remembered from a previous dispute.

Throughout, maintain necessary clinical responsibilities and agreed interim arrangements while seeking advice about the contested terms. Do not use unilateral withdrawal from essential work as a substitute for the correct process. Where an immediate safety issue makes the existing arrangement untenable, escalate that risk through the appropriate clinical and managerial route. The contractual dispute and the safety response should be connected in the record but handled for the distinct decisions they require.

## Repairing the working relationship

A fair decision is important, but so is the ability to work effectively afterwards. Most doctors will continue to collaborate with the managers and colleagues involved. Repair does not require pretending that the disagreement was trivial. It requires a clear account of what has been resolved, what remains open and how future work will be organised. A professional relationship becomes more reliable when expectations are explicit and decisions can be revisited without personal threat.

Write correspondence for the reader who must act on it. State the issue, relevant evidence, requested decision and response date. Avoid a long opening account of motives or historical disappointment. Daniel might write that he seeks reconsideration of the progression decision, identifies the two dependencies recorded in the agreed plan, attaches the dated requests and asks for the applicable criterion to be explained. The tone can be firm without asserting bad faith. Precision makes it harder for the substantive question to be overlooked.

Distinguish acknowledgement from agreement. A manager may accept that study time was cancelled while disputing whether that prevented the objective. Daniel may accept that service pressures were exceptional while maintaining that the progression decision was wrong. Recording these areas of agreement narrows the remaining question. It is not a concession to an adverse conclusion. It allows the discussion to focus on causation, reasonable effort and the contractual consequence rather than revisiting facts that nobody disputes.

Where the decision changes, confirm the practical remedy. Does progression apply from the original date? Who instructs payroll? When will any correction appear? Does the revised job plan replace the previous version, and from when? A courteous message saying that the matter is resolved may leave all of these unanswered. The final record should identify actions, owners and dates. The doctor should then check implementation and acknowledge completion, rather than allowing an administrative omission to reopen the entire conflict.

Where the decision is upheld, obtain a usable explanation and a feasible forward plan. Identify the evidence still required, the support to be provided and the next review point. A doctor can comply with a reasonable development plan while continuing to challenge a disputed decision through the appropriate route. Conversely, pursuing an appeal does not justify ignoring an established requirement. Keep the positions explicit so neither party mistakes participation for withdrawal of the challenge or disagreement for refusal to improve.

The service may also need to learn from the process. Was the review initiated too late? Were the criteria unclear? Did the job-plan template omit dependencies? Was no one responsible for sending the outcome to payroll? These are repairable systems problems. A short improvement in the local process may prevent the same dispute for another doctor. This need not require a large committee: a clearer reminder, named owner, revised form or earlier review can be enough.

Agree how the next conversation will take place. A brief scheduled review of outstanding actions can be more effective than a succession of unanswered emails. State what information should be available and who can make the necessary decision. If the relationship has become strained, an agreed colleague or representative may help keep the discussion focused. Their presence should support clarity, not create an audience for blame. Where trust cannot immediately be restored, reliable procedures and fulfilled commitments can still make everyday work possible while confidence is rebuilt through experience.

Be careful about the audience. Share detailed correspondence with those who need it, including an adviser or representative where appropriate. Broad circulation can harden positions and expose unnecessary personal information. If wider patterns need to be raised collectively, do so through an appropriate representative or organisational route using proportionate information. A legitimate concern is more likely to be understood when its purpose and requested action remain clear.

The desired endpoint is a workable employment relationship supported by accurate records. Daniel should know what the contract requires, what the employer has agreed to provide, what evidence is needed and how disagreement will be handled. His manager should be able to plan the service without relying on hidden work or ambiguous objectives. That clarity does not remove every future conflict. It creates a fairer basis for addressing the next one before it becomes another surprise at a pay review.

Chapter 9

# Working safely within role and resources

## Scope competence and limits

A request to take responsibility can arrive before anyone has described what that responsibility requires. A ward needs cover, a clinic has expanded, or a service has begun accepting patients whose needs differ from its original purpose. The request may sound reasonable because the doctor has managed difficult situations before. Experience is relevant, but it does not answer whether the proposed work can be done safely in the circumstances now present. The decision concerns the combination of the person, the task and the setting.

Good medical practice requires doctors to recognise the limits of their competence. Its emergency duty is also qualified by the doctor's safety, capability and the availability of other care. These requirements belong together: a doctor must offer help appropriate to those circumstances while recognising when additional expertise or a different setting is needed. The requirement to help does not establish competence for every intervention that the emergency might require. [3]

Consider three questions separately. Have I learned to do this work? Have I maintained the relevant capability? Can I exercise that capability with the resources available here? A doctor may answer the first two confidently while identifying a serious difficulty with the third. An experienced proceduralist may lack suitable monitoring or assistance. A senior generalist may recognise a condition requiring treatment that the service cannot provide. Neither situation is adequately described by asking whether the individual is a sufficiently senior doctor.

Scope is also more precise than a specialty label. It includes the patient population, complexity, interventions, degree of independence and circumstances in which advice is needed. Write a short scope statement before accepting a materially different duty. For example: the doctor undertakes independent assessment of the agreed patient group, uses specified investigations, and accesses named specialist advice for defined problems. Then describe what would require direct review elsewhere. Such a statement should allow another clinician to understand the arrangement without knowing the doctor's reputation.

The recurring case in this chapter is a composite teaching example. Dr Elena Morris is a Specialist working in an English community service designed for planned recovery care. A revised referral process begins bringing patients who need more frequent medical reassessment and urgent investigations. Elena has substantial relevant experience, but the service's staffing, diagnostic access and escalation arrangements have not been redesigned. The case does not describe the author, any real employer or identifiable patients.

Elena first distinguishes a development need from an organisational gap. She can identify deterioration and initiate measures within her competence. She cannot create an unavailable diagnostic service by accepting more responsibility. If unfamiliar treatment is proposed, she may also need supervised learning and an assessment of readiness. Those are separate problems with separate solutions. Training is useful when capability is missing; it is not a substitute for equipment, timely advice or an agreed receiving pathway.

A return after extended leave provides another example. A doctor may retain deep knowledge while needing supervised reorientation to a changed system or procedure. A sensible plan names the work to be resumed, the support available, the evidence of readiness and a review point. It avoids a binary choice between immediate full independence and permanent restriction. A limitation that can be addressed should lead to a development arrangement, not an unsupported assumption about the doctor's future career.

There are also occasions when uncertainty becomes apparent after work has started. The useful response is to describe the uncertainty promptly and ask for the necessary help. Earlier acceptance does not prevent reassessment. Explain what has changed: new information, unexpected complexity, absent support or an emerging personal limitation. Colleagues can then contribute to a decision based on the current position. Concealing the change to preserve an impression of confidence makes it harder for the team to adapt.

The scope check therefore has five fields: the duty; relevant current capability; required support; the boundary for additional help; and the person who can agree the arrangement. Complete it for a proposed change, not for every routine consultation. Where an important field remains unanswered, make that the subject of the discussion. The purpose is to turn a vague concern about being comfortable with the work into an explicit account of what safe practice requires. Keep the agreed version with the role documents so that later expansion is visible.

Invite a relevant peer to test the proposed boundary against realistic cases. They may identify an assumption the doctor has missed or confirm that the concern is well founded. Record the resulting clarification, including any development activity, rather than collecting reassurance alone.

## Responsibility without resources

Resources include much more than the number of doctors on a rota. A clinical decision may depend on observations taken reliably, access to the previous record, equipment that functions, an interpretable investigation and somebody able to act on its result. Time and authority are resources too. A doctor can have the knowledge to identify the right next step while lacking the authority to change admissions, redirect work or obtain additional cover. Asking that doctor to be responsible does not itself supply any of these missing elements.

The GMC's leadership guidance expects doctors to use resources fairly and effectively, with responsibilities proportionate to their roles. Those who allocate resources have additional obligations to understand the management arrangements and account for patient safety in their decisions. A management role does not remove professional accountability. These principles support a practical distinction between using what is available and deciding what a service must provide. [47]

In Elena's service, the first resource map follows one patient journey. A referral arrives, information is reviewed, acceptance is decided, the patient travels, observations are taken, medical assessment occurs and an investigation may be needed. For each step, the team names the person, information and facility required. It then repeats the exercise outside ordinary daytime arrangements. The second map exposes dependencies that the first concealed: a laboratory collection schedule, access to previous results and uncertainty about who can authorise urgent transfer.

This exercise is more useful than an isolated assertion that the service needs more senior cover. The missing capability may be timely physical assessment rather than telephone advice. A clinician available remotely may help interpret information but cannot perform an examination through a telephone call. Conversely, an additional doctor on site may not resolve a diagnostic bottleneck. Specify the function before proposing the post. That allows staffing, diagnostic, nursing and operational options to be compared against the same clinical requirement.

Availability needs a practical definition. A number on a contact list proves that a route has been written down; it does not establish that the

intended person is rostered, reachable or able to attend. Ask how competing calls are handled, who acts if the first contact does not respond and how the team obtains help during predictable absence. Test arrangements using a discussion exercise with the people who will operate them. Discovering an unanswered question during preparation is considerably easier to manage than discovering it during deterioration.

Capacity is similarly different from headcount. Two clinicians may have overlapping clinics, supervisory responsibilities and travel. Their names on the same weekly schedule do not make both available for an unexpected assessment. Map the intervals in which a particular function can be delivered, then identify foreseeable collisions. A job plan should make such demands visible, but an unresolved job-plan question does not suspend the need for an interim clinical arrangement. The contractual and operational discussions need to proceed alongside each other.

Information access deserves its own test. Can the receiving team see the referral, recent changes, medication history, pending investigations and the reasoning behind the proposed transfer? A technically accessible record may still be incomplete or difficult to navigate. Ask a colleague unfamiliar with the patient to locate the material needed for the next decision. The exercise assesses the actual information pathway, rather than whether an organisation can truthfully say that it has an electronic record.

Equipment needs an equally practical assessment. Its presence does not establish that somebody can use it, consumables are available or maintenance is current. Ask what happens when it fails and whether staff know the alternative. A service accepting work dependent on that equipment needs a workable contingency, not merely an entry in an inventory or procurement plan.

Decision rights should be written in ordinary language. Who can change the proposed destination? Who can request another assessment before transfer? Who can suspend a particular pathway while a serious defect is corrected? Who resolves disagreement between services? The answer may involve several professionals and an operational manager. It should not depend on finding the most persuasive person on duty. When authority is divided, record the shared decision process and the route for urgent unresolved differences.

A scope and resource safety check can be kept to one page. Its first column describes the work being promised to patients. The second records the capability and resources needed. The third states what is actually available, including important differences by time of day. The fourth identifies the gap, its possible effect and the interim arrangement. A final

column names the decision owner and review date. Avoid a single green tick for a service whose essential components have not been examined individually.

The check should also recognise what works. Reliable nursing observation, established referral relationships or rapid access to advice may provide valuable protection. Recording these strengths helps distinguish a wholly unsuitable model from a viable model needing specific changes. It also prevents a risk discussion becoming a competition between professional groups. The central question is whether the combined arrangements support the patients being accepted, including predictable variation and absence. Responsibility becomes more workable when its supporting conditions can be described and tested.

## Immediate clinical action

When a patient is deteriorating, the first task is the clinical response. A disagreement about staffing, payment or service design can be important without being the immediate priority. Establish the patient's current needs, provide help within competence, obtain appropriate assistance and arrange escalation according to the situation. A risk email sent yesterday does not manage today's deterioration. Equally, a successful response today does not settle whether the underlying service arrangement is sustainable.

Elena is asked to review a newly arrived patient whose condition has changed during transfer. She obtains the information needed for assessment, asks the team to activate the relevant local escalation route and contacts the service capable of providing the additional care required. The example deliberately contains no treatment algorithm: the clinical response depends on the patient and current clinical guidance. The organisational lesson is that immediate care and the record of the pathway problem have different purposes and both need attention.

A brief spoken escalation should make the required decision clear. Identify the patient through the approved clinical channel, explain the change, state what has been done, describe the limitation and ask for a specific response. For example, an urgent physical review may be needed because remote advice cannot resolve the present uncertainty. Agree what happens while help is arranged and who will review progress. A conversation that ends with somebody being aware of the situation may still leave the necessary action unallocated.

If the usual contact cannot respond, use the next appropriate route with urgency proportionate to the clinical risk. Repeating the same unanswered call without reconsidering the plan can consume the available time. Record

the attempts, but do not confuse a list of attempts with a completed escalation. The person receiving the concern needs enough information to understand why a different response is now required. The local escalation policy should help identify the route; clinical judgement remains necessary when events do not follow its expected sequence.

Where two patients need attention simultaneously, make the conflict visible. Describe the competing needs to the relevant senior or operational colleague and seek additional cover or redistribution. Do not silently promise incompatible response times. Prioritisation should follow clinical need, with an explicit plan for the patient whose assessment must wait. The GMC places clinical need at the centre of decisions within the doctor's control and requires action where inadequate systems seriously compromise safety or dignity. [3]

The clinical record should allow the next professional to continue care. Describe findings, relevant uncertainty, the decisions made, communication with the patient or those appropriately involved, the agreed actions and arrangements for review. The separate escalation record can capture the operational contacts and service limitation without turning the patient's notes into a dispute about colleagues. Both records should be factual. Identify an inference as an inference; do not record an assumed refusal when the other person actually described a different proposed plan.

An operational entry might read: the required investigation was unavailable within the necessary clinical timeframe; the receiving clinician and duty manager were contacted; an alternative assessment route was agreed; the team responsible for observation while awaiting transfer was identified. This wording explains the problem and response. It is more useful than saying that the organisation accepts all risk. A declaration cannot transfer every professional obligation, and it gives the next clinician little help with the patient's immediate needs.

Handover is part of the response, especially when the doctor must leave for another emergency or the shift ends. State what remains unresolved, what result is awaited, who will receive it and what change requires further escalation. Confirm that the receiving colleague understands the task rather than relying entirely on a sent message. Where a handover cannot be completed, seek help to establish a safe arrangement. Merely placing an item on a list does not demonstrate that somebody is able to act on it.

Pending investigations illustrate the importance of closing the loop. If a patient moves, the result may still arrive in the original service. Identify who will review it and how relevant information will reach the receiving team. If the expected result does not arrive, agree who will check its status. A

completed transfer can otherwise conceal an unfinished clinical task, particularly when each team reasonably expects the other to receive an automated notification.

After the immediate episode, complete the relevant incident report and any additional clinical communication required by the facts. Do not rewrite the original record to make the sequence look more orderly. If a later factual correction or additional entry is needed, identify it transparently through the approved system. The useful chronology includes uncertainty and imperfect information because those were part of the decision. It should show what was known at the time, what action followed and what became apparent afterwards.

## Recurring system risk

A single difficult episode may reflect an unusual combination of events. Several apparently different episodes may reveal the same underlying dependency. The task is to distinguish these possibilities without waiting for preventable harm. Start with a precise description of the recurring feature. In Elena's case, the issue is not simply that patients are more complex. It is that the revised admission pathway repeatedly creates a need for urgent reassessment and investigation that the receiving service has not been organised to meet.

Choose a small, useful set of observations. These might include referrals requiring clarification, missing clinical information, delayed access to a necessary review and unplanned transfers associated with unavailable facilities. Define each measure so that colleagues count the same event in the same way. Include the period reviewed and the number of relevant patients or referrals. Five delayed reviews among ten cases and five among a thousand describe different frequencies, although either may include a serious individual event.

Do not infer causation from a simple count. An unplanned transfer may be appropriate evidence of a functioning escalation pathway rather than failure. Examine the reason, timing and preceding decisions. Similarly, a low incident count can mean few problems, poor reporting or a definition that excludes the concern. Combine incident records with staff accounts, relevant clinical review and operational information. The aim is a defensible description of the pattern, not a statistic impressive enough to end the discussion.

England's Patient Safety Incident Response Framework emphasises learning and improvement through proportionate responses and attention to systems. It does not make a full investigation of every incident the default.

Use the organisation's applicable arrangements to decide the response; the English framework should not be presented as the governing process for the other UK nations. [48] The practical implication for the doctor is to provide information that helps the organisation understand how work occurred, including the conditions that shaped it.

For a small review, agree access and handling arrangements before collecting information. Use authorised clinical and governance systems. A personal spreadsheet containing patient identifiers can create a new problem while trying to investigate another. Where a summary does not need identifiable information, use aggregated or properly anonymised material. Keep a reference to the authorised source record so that an appropriate reviewer can examine the case without circulating its details widely. The chapter's tools are structures for thought, not permission to establish a private clinical database.

Then separate the hazard from the possible outcome. A missing escalation contact is a hazard; delayed treatment is a possible consequence. The fact that no injury was documented during the review period does not remove the missing contact. Equally, describing the worst imaginable outcome without explaining the pathway to it can weaken a credible concern. Explain how the gap could produce harm, which patients are exposed and what existing controls interrupt that sequence. Ask whether those controls are dependable or rely on informal personal availability.

A risk register entry should support decisions. It needs a clear description, current controls, gaps, an accountable owner and a plan for review under the organisation's system. The score is only one part of that record. A high score without an action owner may produce anxiety without change; a reduced score unsupported by a changed condition may create false reassurance. Ask what evidence would justify changing the assessment. If a control is an additional clinician, has that clinician actually started and are the necessary hours covered?

In Elena's review, colleagues find that an experienced nurse routinely identifies missing information and telephones the sending service. That work has prevented several problems. It is both a strength and a warning. The formal pathway should provide the information; the service currently depends on one person's vigilance to repair it. Record the repair work rather than treating successful outcomes as proof that the original process is adequate. A resilient arrangement should continue to function when that colleague is absent.

Present the pattern to the governance forum capable of influencing the underlying process. Bring a concise account of the agreed pathway,

observed departures, patient consequences or potential consequences, existing protections and proposed changes. Ask for a recorded decision, responsible person and review date. If another forum must decide, establish who will take the matter there. A discussion becomes operationally useful when there is a route from the evidence to a person able to alter the condition.

Follow-up should test the relevant change rather than count meetings. If the concern was absent review cover, examine whether cover became available when needed. If it was incomplete handover, examine the information received. Keep the original concern and subsequent evidence linked so that the issue is neither repeatedly reopened from memory nor closed simply because time has passed. A persistent risk may need escalation beyond the first forum, but the accumulated record should make that escalation clearer and more focused.

Small numbers require careful interpretation, not inactivity. Explain what the available sample can show and what remains uncertain. An evident missing safeguard can justify a practical correction while further information is collected. Set a proportionate review period instead of waiting indefinitely for a statistically persuasive adverse outcome.

## Delegation supervision and team capability

Team capability depends on the match between the task, the person and the support around them. Professional titles provide useful information but cannot answer every question about an individual's current competence. A doctor new to a service may need help with local systems; an experienced nurse or allied professional may hold substantial expertise in a defined area. The practical discussion should describe the work, legal or professional boundaries where relevant, and the supervision needed. It should avoid both automatic deference and automatic dismissal based on title.

The GMC distinguishes delegation, where a colleague provides care on the delegating professional's behalf, from referral, where another professional or service takes over part or all of care. Its guidance makes accountability specific: the doctor remains accountable for the decision, instructions and safety steps, and for overall management when they are the responsible clinician. Appropriate delegation does not make the doctor automatically accountable for every action or omission of the recipient. The recipient also has responsibilities for accepting and carrying out the task safely. [7]

That distinction is useful when a rota says that a junior colleague covers a service with senior support. What work is being delegated? Does the junior

doctor have the relevant experience? What supervision is required and how will it be accessed? Is the senior doctor providing advice, attending when necessary or retaining a defined responsibility for the patient group? An arrangement can be described as supervised while leaving these practical matters unresolved. Write them down before relying on the label.

Elena and a colleague rehearse an evening referral. The receiving doctor explains what information they would gather, what they can decide independently and what would prompt a call. Elena describes what she can provide remotely and the circumstances requiring a different response. They discover that the existing document assumes she can attend immediately, although the rota makes no such provision. The exercise identifies a design problem before either clinician has to interpret an ambiguous promise during an urgent episode.

Instructions should include the purpose of the task and the point at which the plan must be reconsidered. Asking somebody to check a result leaves uncertainty about what checking means. Does the person need to confirm that the test occurred, interpret its significance, communicate it or arrange treatment? Allocate those steps deliberately. For important or unfamiliar tasks, ask the colleague to explain the plan in their own words. This tests shared understanding without turning every conversation into a formal assessment.

Document material changes to that allocation where the team can find them. An agreement reached verbally on one shift should not leave the next shift following an obsolete plan.

Supervision also consumes capacity. A senior doctor repeatedly interrupted to advise several colleagues may no longer have the uninterrupted time assumed for another task. Record that pattern when reviewing the job plan and service design. Creating a supervisory role on paper without allocating availability can increase uncertainty for everyone. Consider predictable peaks, absence cover and the supervisor's own clinical commitments. If supervision is essential to safe delivery, its interruption or disappearance needs an alternative arrangement just as any other essential service component does.

The receiving professional needs a usable route to say that the task cannot safely be completed. Encourage early questions and a clear account of the difficulty. Perhaps the patient is more unwell than expected, essential information is missing or the requested action exceeds current capability. Respond to the new information before considering whether the original allocation was appropriate. A team that treats every request for help as a

disappointing performance creates an incentive to conceal uncertainty until the choices become narrower.

Cross-professional work requires particular clarity about responsibility for prescribing, investigation requests, interpretation and follow-up. Do not assume that access to a computer function establishes professional authority or that a local custom changes the relevant regulatory boundary. Where a proposed role redesign alters these tasks, obtain the appropriate professional and governance review. For routine collaboration, the immediate objective remains straightforward: every clinically necessary action should have an identifiable person who understands it, can undertake it and knows where further help is available.

At handover, transfer an actionable plan rather than an undifferentiated list. State the current issue, next task, expected timing, escalation trigger and receiving person. If care is divided between services, make the division understandable to the patient as well as the team. The strongest arrangements allow a competent new colleague to enter the service and discover how responsibility operates without having to decode unwritten relationships.

## Service pressure and moral distress

Repeated exposure to care that falls short of what a doctor believes patients need can be deeply unsettling. The distress may include frustration, guilt, anger or a sense of having become complicit in an arrangement the doctor has challenged. The term moral distress can help describe that experience, but it should not become a diagnosis applied casually to colleagues. Ask what the person is experiencing, what situation is producing it and what support they want. The emotional response and the underlying service concern both deserve attention.

Pressure can distort the way a doctor interprets responsibility. After an adverse event, it may feel as though greater personal effort would have prevented every difficulty. A careful review asks what was within the doctor's control, what depended on others and what options were actually available. This is not a search for excuses. It makes learning more accurate. Otherwise the proposed remedy may be an unrealistic promise to work faster, stay later or remain constantly reachable while the missing service provision remains unchanged.

Fatigue requires an operational response as well as personal recognition. HSSIB's investigation of staff fatigue identifies risks to patients and staff and describes weaknesses in how healthcare organisations recognise and manage those risks. It treats fatigue as a system issue requiring attention to

working conditions and organisational arrangements. Its findings concern the English system and do not establish a uniform contractual rule for every UK doctor. [49] The relevant question for an individual is what action is needed when fatigue compromises safe work now.

A practical discussion can be specific: the doctor describes the work already undertaken, the difficulty concentrating or functioning, the next scheduled duties and the cover required. Contact the appropriate senior or operational colleague to agree an immediate arrangement and a safe handover. Consider safety after the shift, including travel, rather than assuming the risk ends at the hospital door. Repeated episodes should feed into a review of actual workload, recovery and on-call arrangements, alongside any personal health assessment that is appropriate.

Support has several functions. Occupational health can help assess the relationship between health and work and advise on adjustments. The doctor's own treating clinician addresses personal healthcare needs. A trusted colleague or mentor can help examine a difficult experience, and professional support services may provide additional assistance. A trade union adviser addresses employment questions; a medical defence organisation can advise on professional obligations and medicolegal concerns. Choosing the right function helps avoid expecting one conversation to solve every part of the problem.

Elena recognises that she has begun checking messages on days away from the service because she worries that nobody else will notice a problem. The habit is understandable, but it masks the absence of a dependable cover arrangement. She records the tasks that prompted contact and asks the service to establish a rota-based route. She also discusses the effect on her wellbeing with an appropriate professional. The objective is a system in which her absence is planned, not an assurance that she will remain available indefinitely.

A colleague may disagree about how serious the problem is. Treat that as information to examine rather than evidence of indifference. They may see a different part of the work or have access to support others do not. Compare the actual circumstances and the standard being applied. Conversely, repeated reassurance that everyone is under pressure does not answer a documented resource gap. Return to the concrete condition, the possible effect and the change needed, while keeping the personal impact visible.

An immediate support plan can remain brief: the current difficulty, the person providing help, the temporary adjustment and the review point. It should not require the doctor to disclose private health details to an entire team. A separate service plan addresses the operational risk. Keeping these

plans connected but distinct allows recovery without implying that the concern arose only because the doctor was distressed. It also allows improvement work to continue without making an exhausted clinician its sole owner.

Agree who will check that the temporary arrangement is working. A supportive conversation can lose its effect when the next rota reproduces the same exposure. Review the work actually undertaken, the support received and whether a further adjustment is needed.

## Raising concerns

Raising a concern begins with stating what needs attention and why. It does not require a doctor to complete an investigation before speaking. The GMC expects concerns about patient safety to be raised through appropriate channels on an honest, reasonable basis; immediate serious risk needs an immediate report. Where the local route is unsuitable or inadequate, its guidance identifies circumstances for approaching a relevant external body. Keep a record of the concern and the steps taken. [37]

Start with the local policy and the urgency of the issue. A clinical director, medical director, governance lead or another designated person may be the appropriate first contact. If that individual is implicated in the concern, use an alternative route identified by the policy or obtain advice about the next step. A process designed for routine correspondence should not delay urgent clinical action. Nor should a doctor's uncertainty about the ultimate investigation route prevent a clear report to somebody able to address immediate risk.

In England, NHS England's national speak up policy sets a minimum standard for local Freedom to Speak Up policies. The local version supplies organisational contacts and implementation details. A Freedom to Speak Up guardian can help a worker navigate speaking up, but the doctor should establish who will investigate the issue and who can change the service. The route for support and the authority for operational decisions may involve different people. [50]

In Wales, use the Welsh Government's Speaking Up Safely framework alongside the employer's current raising-concerns procedure. The framework supports rather than replaces existing procedures and addresses organisational culture, responding to concerns and monitoring what follows. Do not assume that the English national policy or a particular English job title defines the Welsh route. Find the named local contact and establish how the concern will be recorded, which process will handle it and how feedback will be provided. [51]

Scotland has National Whistleblowing Standards overseen by the Independent National Whistleblowing Officer, a role undertaken by the Scottish Public Services Ombudsman. The standards describe a framework for NHS service providers handling whistleblowing concerns and extend beyond directly employed staff to others delivering NHS services. Use the provider's arrangements and the INWO information to identify the appropriate route and any next stage. This is a distinct system, not a Scottish name for England's Freedom to Speak Up policy. [52]

In Northern Ireland, the Department of Health's HSC Whistleblowing Framework and Model Policy provides the national reference alongside the employer's current policy. Its model includes alternatives where raising an issue with the line manager is unsuitable, including designated advisers or advocates and relevant governance or HR contacts. Follow the current local arrangements rather than treating an illustrative model contact as a person already appointed in every organisation. [53]

The language of speaking up is wider than the legal category of a protected disclosure. In Great Britain, Acas explains that legal whistleblowing protection depends on relevant conditions, including reasonable belief that the disclosure concerns specified wrongdoing and is in the public interest. A personal grievance does not automatically satisfy those conditions. Northern Ireland has its own statutory framework and official guidance; the Labour Relations Agency provides employment advice there. Obtain individual advice when protection or possible detriment becomes an issue. [54][55]

The escalation record can use seven prompts: what was observed; when and where it occurred; why it matters; which patients or service functions are affected; immediate action already taken; the decision requested; and who received the concern. Add the agreed response, owner and date when known. Distinguish direct observation from information supplied by another person. Where the concern overlaps with a grievance, state that overlap openly while making the patient-safety issue intelligible in its own right. Avoid guessing motives.

After a meeting, send a short factual confirmation through the appropriate secure channel. State your understanding of the agreed action and invite correction if it differs from the recipient's understanding. This is especially useful when several concerns were discussed together and only some could be decided by those present.

Ask about confidentiality before assuming anonymity. A confidential concern is handled with limits on disclosure; an anonymous concern does not identify its source. Either arrangement may have practical limits,

particularly where a detailed event is readily recognisable or action requires speaking with other people. Discuss how information will be shared and what support is available. Do not promise a colleague secrecy that prevents necessary safety action. Explain the limits and seek appropriate advice on the particular circumstances.

Medical defence organisations can help doctors consider professional obligations and the wording or route of a concern. The MDU's guidance emphasises raising concerns appropriately and seeking advice, particularly before wider disclosure. [56] Employment representation may also be needed if the doctor experiences adverse treatment. Keep a factual chronology and seek advice promptly; do not assume that continuing an internal process settles or preserves every external legal option. Public statements and social media require particular care because confidentiality and legal protection are not resolved by the sincerity of the concern.

If the response remains inadequate, return to the evidence: what risk persists, which action was promised and what has actually happened? Ask for the next responsible level and obtain advice about external routes where necessary. The appropriate body depends on whether the concern concerns an individual professional, an organisation or another regulated activity. Sending the same broad allegation to many bodies can obscure that distinction. A focused, properly directed concern gives the recipient a clearer basis for action.

## From concern to service change

An effective concern creates the conditions for a decision. It tells the reader what is happening, why it matters and what must now be agreed. A long chronology may be necessary as supporting evidence, but the decision-maker usually needs a concise service-risk brief first. This is particularly important when the person receiving the concern did not design the pathway and does not share the clinical team's background knowledge. Write for that reader without removing the detail needed to understand the risk.

Begin with the gap between the intended service and its current work. Elena's brief states that a recovery service is receiving patients needing an intensity of review and investigation beyond its established arrangements. It identifies the changed referral process, the functions that are unavailable and the resulting delays or additional transfers. It does not accuse an unnamed group of disregarding safety. The concern is serious because the work and its supporting conditions no longer match, regardless of how that mismatch arose.

The next paragraph describes the current protections and their limitations. These may include clinical triage, experienced staff, telephone advice and escalation to another service. Explain which protections are reliable and which depend on informal availability or repeated workaround. Then state the residual problem. This prevents an apparently reassuring list of controls from being mistaken for evidence that the entire pathway is safe. A control can reduce a risk without removing the need for further action.

Offer a small number of realistic options. For Elena's service, one is to retain its previous patient group while the wider pathway is redesigned. Another is a defined expansion supported by additional assessment capacity, agreed diagnostics and an effective escalation arrangement. A third may be a staged change with narrower initial criteria and explicit review. These are illustrative options, not recommendations for a particular NHS service. Each must be assessed against the needs of patients who would otherwise remain elsewhere.

Compare options using the same questions. What care can be delivered, by whom and when? What new resource or agreement is required? What risks remain? What effect will the option have on the sending service and patients awaiting care? Who can authorise it? An option that transfers delay to another part of the pathway may still be preferable, but that consequence should be visible. The aim is an honest comparison of whole-pathway effects rather than improving one service's figures by moving the problem.

The brief should distinguish an interim arrangement from the intended model. Temporary changes need an owner, start point, review date and a means of stopping or modifying them if they fail. A permanent solution may require recruitment, training or commissioning decisions that cannot be delivered immediately. That delay should not leave the interim period undefined. State what can happen now, what must wait and how the team will respond to cases outside the agreed arrangement while the larger change is developed.

Name the circumstances requiring an earlier review so that the calendar does not override deteriorating conditions.

Before implementation, test the proposed model with a small set of realistic situations. Use an ordinary referral, an incomplete referral, unexpected deterioration and simultaneous demands on the same clinician. Include an absence or equipment failure. Ask the actual receiving, sending and operational teams to walk through their actions. The test is not successful because everybody agrees with the diagram. It is successful when each necessary action has an identified person, the information reaches them

and unresolved dependencies are corrected before patients rely on the process.

Choose review measures that correspond to the original concern. If the problem was timely reassessment, measure the relevant interval and examine outliers. If incomplete information was central, sample the handovers received. Include a balancing measure so that improvement in one place does not conceal worsening elsewhere. Staff and patient accounts can reveal problems missed by simple counts. Specify who will collect the information through approved systems and who will decide whether it supports continuation, modification or a different model.

At the review meeting, distinguish completed actions from demonstrated effects. Publishing a policy is an action. Showing that staff understand and can operate it is evidence about implementation. Showing that the original problem has reduced without a new unacceptable consequence is evidence about effect. All three matter, but they answer different questions. A service can finish its action list while leaving the practical difficulty substantially unchanged. Closure should therefore refer to the condition that prompted the concern, not only to the paperwork produced afterwards.

Elena's contribution need not make her the permanent owner of every improvement. The service-risk brief names clinical, operational and executive responsibilities according to the decisions each person can make. Her agreed role may include clinical advice and a defined review, with time recognised in the job plan. Continuing responsibility for staffing or pathway coordination belongs with the designated owners. This makes the improvement more sustainable and preserves an intelligible account of what she is expected to deliver.

The final test is whether another team could use the arrangements during Elena's absence. Patients should receive appropriate assessment, colleagues should know their responsibilities and unresolved concerns should reach somebody able to act. The doctor has helped connect immediate care, evidence, organisational decisions and review. That is the practical purpose of working safely within role and resources: professional responsibility remains active, while the conditions required to discharge it are made explicit and pursued through a workable service arrangement.

Chapter 10

# Annual appraisal

## Purpose and boundaries

Michael arrives at appraisal with a substantial collection of documents and an unexpectedly incomplete account of his year. His hospital work is well represented. His management responsibilities appear only in a job title, his teaching is represented by attendance certificates, and his external professional work is absent. Asked what he learned from a difficult service change, he searches for the presentation he gave afterwards. He can show that he was busy. It is harder to explain how his decisions developed, what others experienced and which arrangements need attention before the next year begins.

Michael is the composite Associate Specialist introduced elsewhere in this handbook. For this chapter, assume that he works in England, holds a longstanding substantive appointment and undertakes a separately agreed external educational role. His difficulty is common in established careers. Familiar work receives little explanation because the doctor understands it so well. Unfamiliar administrative requirements receive disproportionate attention because they threaten to delay completion. A useful appraisal reverses that imbalance. The records prepare a professional conversation about the actual work, its quality, the doctor's development and the conditions affecting both.

Annual appraisal is a structured opportunity to review professional practice with a trained appraiser. It contributes information to revalidation but is not itself the GMC's licensing decision. It is also distinct from the meeting that agrees the job plan and from a formal procedure investigating capability or conduct. NHS England's appraisal resources point to the Medical Appraisal Guide as an approach to this supported review; delivery arrangements must still be established with the relevant organisation. These distinctions protect the purpose of the discussion without making it detached from professional accountability. [16]

The practical question is not whether an awkward subject belongs in appraisal. A difficulty may affect learning, wellbeing or the safety of practice and deserve discussion. The question is what the appraisal can do about it. An appraiser can help Michael understand an unsupported responsibility, record its effect and identify a development or organisational

action. The appraiser cannot allocate a budget on the employer's behalf. An agreed PDP objective cannot quietly become approval for additional clinical duties. A concern needing urgent action must enter the appropriate governance route when it arises.

The six GMC supporting-information categories provide the evidence framework: continuing professional development, quality improvement activity, significant events, patient or service-user feedback, colleague feedback, and compliments and complaints. They are different ways of examining practice, not six independent competitions to accumulate documents. Their collection requirements are also different. Some relate to the year since the last appraisal; others require planned activity across the revalidation cycle. This chapter explains those differences before showing how to bring them into a proportionate annual account. [57]

Begin by writing three sentences before opening the portfolio. Describe the work undertaken, the most important learning or change, and the matter that needs help or a decision. Michael might explain that he maintained his clinical service, learned that an educational arrangement depended too heavily on his availability, and wants to plan a supported handover. That opening gives the appraiser a route through the material. It does not replace the required declarations; it stops them becoming the only visible purpose of the meeting.

An appraisal should leave an accurate account of the discussion and a realistic plan. It need not portray an exceptionally successful year. Illness, delayed projects, competing demands and a change of direction can all produce meaningful learning. Equally, a comfortable conversation is not sufficient if substantial roles or relevant concerns have been omitted. The reader's task is to make the professional picture intelligible, respond honestly to questions and distinguish what has been achieved from what remains proposed. The result should be useful both to the doctor who returns to it and to the authorised person who later considers its outputs.

## Connection platform and timetable

The first preparation task is administrative because an otherwise excellent appraisal can be undermined by being arranged through the wrong route. Confirm the designated body or other recognised revalidation connection in GMC Online, identify the appraisal office and establish how an appraiser is allocated. The GMC connection tool helps doctors determine their prescribed connection; a convenient colleague or familiar portfolio supplier does not determine it. Chapter 11 examines the connection rules in greater

detail. Here the immediate objective is to know who expects the appraisal and how its completion reaches the correct system. [9]

There is no single electronic appraisal platform for every UK doctor. In Wales, MARS is the all-Wales Medical Appraisal Revalidation System provided by HEIW. Its public entry page distinguishes medical and GP access and directs new users to appraisal and revalidation support. In Scotland, the Medical Appraisal Scotland service provides SOAR and associated guidance. England's organisations use their own approved arrangements, while Northern Ireland's Department of Health provides the national revalidation framework and employers supply operational instructions. A doctor moving between nations should obtain the receiving organisation's current process rather than assuming an existing login transfers the obligation. [17][18][19]

Separate three dates: the annual appraisal window, the deadline for submitting preparatory material, and the GMC revalidation submission date. They serve different purposes. A local portfolio deadline allows an appraiser to review information before meeting. The appraisal date marks the annual conversation. The revalidation submission date concerns the recommendation process. Put all three in the diary with their source and the responsible contact. If a date looks inconsistent, resolve it before deciding which one can safely be ignored.

An eight-week preparation plan is a useful working method, not a national requirement. At eight weeks, confirm the appointment and review the previous summary and PDP. At six weeks, request information that depends on others: external governance statements, feedback reports and confirmation of outstanding actions. At four weeks, select supporting information and draft reflections. At two weeks, check declarations, explain any gaps and submit within the actual local deadline. During the final week, prepare the questions worth discussing. After the meeting, check the summary and agreed actions promptly.

This sequence works because it separates collection delays from reflective work. Michael can write about a teaching improvement in an afternoon, but an external organisation may need several weeks to produce governance information. Aisha, preparing for her first appraisal in an NHS Specialty Doctor post, may need help identifying information held by a previous employer. Both should make those requests early. A short list recording the item, owner, request date and expected response is more useful than repeatedly opening the portfolio to see whether it feels complete.

Technical access deserves an early check too. Make sure that the account uses an address that will remain accessible throughout the process, that the

appraiser can see submitted material, and that attachments open correctly. Keep an authorised personal copy of final appraisal outputs where local policy permits, protected appropriately. Do not download confidential source records merely because a portfolio account may close. If access fails close to the deadline, notify the appraisal office with the error, time and attempted remedy; ask for an approved submission route and retain that correspondence.

Finally, tell the appraiser about any preparation need that could affect the meeting: additional time, accessible documents, a private remote location or an unfamiliar part of the scope. This is not an invitation to negotiate away substantive requirements. It allows the conversation to be arranged properly. If the allocated appraiser has a conflict or a relationship likely to inhibit a fair discussion, raise it through the appraisal office before sharing sensitive material. Early clarification is usually easier than trying to repair a disputed summary after an uncomfortable meeting.

## Whole scope of practice

The portfolio should describe the doctor's professional work, not merely the activity visible to the largest employer. The GMC expects declaration and supporting information across clinical and non-clinical roles, including NHS, independent, voluntary and private work. Educational, managerial, research and leadership responsibilities can therefore matter even when they occupy little time. Supporting information should normally arise from UK practice; overseas work needs early discussion with the responsible officer about acceptability. Evidence volume should be proportionate, with meaningful examples rather than repeated demonstrations of the same learning. [58]

Construct a scope map with one entry for each role. Record the organisation or setting, dates, nature of work, approximate commitment, level of responsibility, governance contact and evidence available. Include roles that ended during the year as well as those still active. The map is a working document, not an official substitute for the platform's declarations. Its value lies in making omissions visible. If the diary records regular teaching but the scope map contains only clinical work, something needs explanation before the evidence is assessed.

For Michael, four entries emerge. He provides inpatient and outpatient clinical care in his substantive employment. He leads a service improvement group under a separate responsibility within that organisation. He teaches on an externally organised professional course. He contributes to a professional committee with educational work. These activities overlap, but each

presents different questions. Clinical evidence may concern outcomes and communication. The improvement group requires an account of his contribution and what changed. External teaching calls for feedback and appropriate governance information. Committee work needs proportionate reflection on its professional relevance.

The map should not inflate every meeting into a separate job. A governance meeting within clinical employment can usually remain part of that role. The purpose is to distinguish work whose responsibilities, organisational oversight or evidence source differ materially. If a doctor undertakes occasional paid medical reports outside the NHS, that work is not automatically covered by a hospital complaints statement. If an external role is genuinely non-medical, explain its relevance rather than insisting that every hobby belongs in a regulated professional scope. Ambiguity is best resolved by describing the activity accurately.

Next, ask how concerns and feedback would become known. A statement from the principal employer may address incidents in its own systems but say nothing about another organisation. Request the appropriate governance information through the receiving appraisal or responsible-officer arrangements. A useful request identifies the period, role and information required, instead of asking vaguely for a reference. The doctor should distinguish a general endorsement from a governance confirmation. Someone may value Michael's contribution while having no authority to report whether a formal concern has been recorded.

Evidence should then be mapped against the questions each role raises. A teaching programme evaluation can inform quality improvement and service-user feedback, while a reflective account explains what Michael changed. A management role may draw on a reviewed process, stakeholder feedback and development undertaken for the responsibility. This does not mean that one favourable teaching evaluation answers every supporting-information category. The mapper should show both what an item supports and what it cannot establish. Chapter 12 develops this disciplined reuse of evidence across different professional purposes.

Consider an apparent gap: Michael has no individual patient feedback from an external educational role because that role has no patients. The gap is not resolved by attaching more hospital questionnaires. He needs an appropriate account of feedback from those receiving that professional service and agreement about the approach. A second gap is different: he has not sought any information about complaints in that role. Lack of direct patient contact does not make governance irrelevant. Distinguishing the two

prevents an exemption in one category being mistaken for exemption from the entire role.

Changes during the year deserve their own explanation. If Michael reduced clinical sessions to undertake leadership work, the evidence available may change before the portfolio's categories do. If Aisha started a new post halfway through the year, an appraisal should show the preceding employment period and the new responsibilities without implying twelve months of exposure to either. Give dates and describe what was possible. Where a role stopped, record any continuing action or unresolved concern and how information will remain available after access to its systems ends.

The final test is to read the scope map as someone who has never met the doctor. Can that reader identify where the work occurred, what the doctor did independently, where support existed and how its quality was reviewed? Can they see a reasonable connection between the declared work and the selected information? A portfolio may be concise and still answer those questions well. Conversely, a large portfolio can leave an entire professional role invisible. Completeness concerns the professional picture; it does not require indiscriminate uploading of every record generated within it.

Keep that map available between appraisals. When a new responsibility is accepted, add it while its boundaries are clear and identify the evidence contact then. Waiting until the annual meeting risks discovering that the only person able to describe the arrangement has moved on. A brief contemporary entry can preserve the agreement's meaning without creating another extensive portfolio task.

## Continuing professional development

Continuing professional development should start with a question arising from the work. What needs to be maintained, improved or learned for a forthcoming responsibility? The GMC requires CPD every year, across the whole scope, with reflection on its contribution to practice. It does not prescribe a universal number of CPD points for revalidation. College schemes and local expectations may provide additional structures, but a points total is not the regulator's substitute for relevance and learning. A doctor's plan should therefore make the connection between professional need, chosen activity and its intended use visible. [59]

A certificate answers a limited question: it may establish attendance or completion. It rarely explains the clinical uncertainty that prompted the activity or whether anything useful followed. Begin a CPD entry with that uncertainty. For example, Michael notices that he can describe the service's new referral process but cannot explain consistently which cases need a

different pathway. He reviews the approved guidance, discusses difficult examples with colleagues and tests his understanding against subsequent referrals. The learning is the clarified decision process; a course could contribute, but is not the only possible route.

Use four short elements in a learning record. Describe the need, what you did, what you understood differently and what followed. If nothing changed because the learning confirmed existing practice, explain what it confirmed and why that matters. If the activity was disappointing, identify the unresolved question and the next source. The entry need not turn every journal article into an essay. Group related reading around a coherent question, while retaining enough detail to identify the sources and distinguish genuine engagement from an unexamined bibliography.

The whole-scope map helps prevent clinical CPD from eclipsing other responsibilities. Michael's clinical updates do not necessarily prepare him to supervise a struggling learner or chair a difficult service meeting. Equally, attending several leadership events does not maintain competence in a changing clinical field. Allocate learning according to the demands of the work and the consequences of gaps. A low-frequency but high-consequence task may require deliberate rehearsal or supervised updating even though it contributes few entries to an activity log.

For Aisha, a learning need may combine clinical knowledge with the local application of an unfamiliar system. She might understand a condition well but need to learn the receiving organisation's escalation arrangements or documentation process. Her appraisal entry should not imply lack of medical competence simply because induction was necessary. It should describe the precise gap, how she addressed it and how she confirmed understanding. This distinction enables useful development without converting every difference between healthcare systems into a judgement about the doctor's overall capability.

Evidence of application should remain proportionate. A later peer discussion, an appropriately anonymised review or feedback on a changed explanation may be enough to show how learning informed practice. Do not invent an outcome measurement for a question it cannot answer. Attendance at a communication workshop cannot prove fewer complaints; a small review may show that explanations became clearer without establishing a causal effect on service outcomes. The appraisal discussion benefits from the doctor stating both the useful finding and its limits.

Professional development also requires resources. If an agreed objective depended on study leave, supervision or access to a course that was not available, record the request and outcome. Explain what alternative learning

was possible and what remains unresolved. The appraisal can identify the dependency and feed a practical request into job planning. It should not rewrite an unmet organisational commitment as a personal failure. At the same time, the doctor should consider reasonable alternatives rather than treating cancellation of one event as the end of the learning need.

At the annual review, choose the few CPD examples that best explain the year's professional development. Keep the wider record available, but guide the conversation towards learning that changed a decision, addressed a risk, maintained an important capability or prepared a new responsibility. Ask what is still uncertain and which future opportunity would make the greatest difference. A good CPD account turns the next year's plan into a response to actual practice rather than a shopping list of courses.

## Quality improvement and significant events

Quality improvement activity examines the quality of work and the effects of attempts to improve it. The GMC requires active participation in relevant activity at least once in the revalidation cycle, with the type, amount and frequency appropriate to scope and agreed through the responsible-officer arrangements. It also expects regular review and audit of work, including participation in national audit or outcome review conducted in the doctor's area of practice. Even where direct participation is impossible, the doctor must reflect on its outcomes. A relevant activity may include clinical audit, case review, evaluation of teaching or examination of management practice. Outcomes and subsequent actions should be discussed; an unevaluated change needs a plan for follow-up. [60]

For the SAS doctor, the first challenge is often recognising work already undertaken. A structured review of referral decisions, contribution to a prescribing audit or redesign followed by evaluation may provide useful evidence. Merely attending a governance meeting does not show active participation in improvement. State the question, the standard or intended outcome, the doctor's contribution, the findings and the response. Where the activity belongs to a team, describe the team achievement fairly and identify the individual role without appropriating work performed by others.

Take a composite example from Michael's educational responsibilities. Learners report that the course explains professional principles well but leaves uncertainty about applying them in unfamiliar situations. Michael and the faculty review the comments, introduce short decision exercises and repeat the evaluation. His appraisal account can explain the change in teaching design and what the subsequent responses suggest. It should also acknowledge that participant satisfaction is not the same as demonstrated

performance in practice. A useful next step might be a later assessment of application, if proportionate and feasible.

Clinical improvement needs similar precision. Suppose a team reviews whether follow-up responsibility is explicit in discharge communication. A baseline review finds that responsibility is often implied rather than recorded. The team changes the template, clarifies ownership and repeats the review. Michael should explain how cases were selected, what counted as an explicit allocation and whether the repeated sample was comparable. If compliance improved in a small sample, describe that result accurately. Do not infer that all communication failures have been prevented or that the change alone caused an improvement in patient outcomes.

An incomplete project can still support an honest appraisal discussion. The useful distinction is between no evaluation yet and a claim of success without evaluation. If the second review is delayed, record why, who owns it and when it will be revisited. If the change failed, describe what the failure revealed. Perhaps staff understood the new template but competing systems encouraged duplication; perhaps a standard was poorly defined. The appraisal should help translate that learning into the next action. It should not require a decorative success story to justify the time invested.

Significant events form a separate category. The GMC describes events that unexpectedly or unintentionally caused, or could have caused, patient harm. Doctors must declare and reflect on every relevant event in which they were involved since the previous appraisal, including involvement as part of the treating team. Discussion can concentrate on events that best demonstrate learning or change, while declaration remains complete. If none occurred, the doctor should declare that and consider the reporting process or preventive work. Local incident terminology may differ from the GMC category. [61]

This distinction matters when an organisation's label is narrower than the learning requirement. A near miss should not disappear merely because it was not classified locally as a serious incident. Equally, an appraisal entry should not imply that the doctor caused every event involving their team. Describe the nature of involvement accurately, separate established findings from matters still under review, and focus the reflective account on learning. The incident report, factual statement and clinical record perform other functions and should remain in their appropriate systems.

Consider a composite incident in which a follow-up action was not clearly handed over between services. Michael was one member of the treating team. His reflection can examine what he understood about ownership, how the ambiguity became apparent and what he now checks. It

can also identify a system problem: the handover process allowed an action to appear assigned without confirmation that the receiving team had accepted it. Personal learning and system analysis belong together. Neither the statement that the system failed nor a promise to be more careful is an adequate complete account.

Follow-through gives the reflection practical value. Record which action the doctor completed, which the team agreed and which needs organisational authority. If the employer is considering a wider redesign, do not claim it as implemented. At the next review, examine whether the immediate change persisted and whether the unresolved action was escalated appropriately. Learning may include recognising that a proposed safeguard creates a different burden or fails during out-of-hours work. The evidence should preserve that complexity while remaining clear enough to support a decision.

Quality improvement and incident learning can overlap without becoming interchangeable. A significant event may prompt an audit; the audit may reveal a wider pattern; a later review may test the response. Cross-reference the related material rather than duplicating an entire narrative under every category. The appraisal then follows one intelligible sequence: concern, investigation, learning, action and review. It remains essential that urgent concerns were handled through governance at the time. The annual conversation is a place to examine what followed, not the first destination for a patient-safety problem awaiting action.

## Feedback complaints and compliments

Feedback introduces perspectives that self-assessment cannot supply. The GMC requires a formal patient-feedback exercise at least once during each revalidation cycle and reflection on relevant other feedback at annual appraisal. Where there are no patients, feedback from recipients of the medical service may be appropriate; inability to collect it requires agreement with the responsible officer or suitable person. Collection should fit the population and setting, allow accessible participation and minimise selection bias. A separate formal survey for every role is not invariably required, but the approach must represent the scope meaningfully. [62]

Plan the exercise before the final revalidation year. Ask which approved mechanism is suitable, who will administer it and what practical support patients need. A clinic questionnaire may work poorly for people with communication difficulties, those receiving care during severe distress or patients seen only briefly. The response is to design a defensible approach with the relevant support, not to conclude that these patients have no

perspective worth hearing. Feedback from carers or representatives may help where appropriate, while remaining clearly identified as their perspective.

Colleague feedback is also required at least once per cycle. The GMC expects an impartial selection across the whole scope, including different professional roles. Validated questionnaires administered independently should be used wherever possible; alternatives need agreement. Numerical response recommendations belong to the chosen tool and circumstances, rather than a single universal GMC quota. The doctor should compare the findings with self-assessment and reflect on their significance for future practice. A group composed only of close medical colleagues is unlikely to illuminate the full experience of working with the doctor. [63]

Michael therefore includes colleagues who see different parts of his contribution, following the approved process. Some experience his clinical decisions, others his teaching or leadership. The point is not to secure equally favourable scores in every setting. It is to discover whether the same professional behaviour is experienced differently. A doctor who appears calm and decisive in clinical work may be perceived as hurried or inaccessible in a committee role. That difference can generate a specific question about preparation, availability or communication without becoming a verdict on personality.

Read feedback slowly enough to separate a pattern from an isolated comment. Ask what the respondent may have observed, whether other evidence supports the concern and what action would be proportionate. A defensive first response is understandable, but it is not a useful final interpretation. Neither should every adverse comment be accepted as fact. Discuss uncertainty with the appraiser, retain professionalism towards respondents and consider whether further information is needed. The practical objective is a tested understanding of the behaviour that can improve, not discovery of who wrote an unwelcome sentence.

Complaints require a distinct account. The GMC requires declaration and reflection on all formal complaints about the doctor or their practice since the previous appraisal; this includes relevant complaints involving the team. Informal complaints and compliments can also supply learning. At the meeting, selected examples may receive most attention because they demonstrate insight or change, but selection for discussion must not conceal the full declaration. Where no complaint names the doctor, relevant local feedback can still inform reflection. [64]

A complaint is an allegation or expression of dissatisfaction, not automatically a finding of wrongdoing. Record its status and outcome

accurately. If an investigation remains open, say so and distinguish learning already possible from conclusions not yet established. For example, a dispute about what was explained may prompt clearer checking of understanding without requiring the doctor to accept an inaccurate account of the original consultation. If formal proceedings are involved, obtain appropriate advice on statements and disclosure. Appraisal reflection should not become an improvised legal defence or substitute for the response required elsewhere.

Compliments deserve more than storage as reassurance. Ask what enabled the good experience and whether it can be sustained or shared. A family may value consistent communication between teams; a learner may value a supervisor explaining uncertainty openly. These comments can reveal effective habits that become invisible through familiarity. Bring patient, colleague and other feedback together at the level of learning: what should continue, what should change, and how will the doctor know whether the response helped? The next appraisal can then revisit a decision rather than repeat a score.

When discussing a survey, keep its limitations visible. A response rate may be low, the timing unusually difficult or a particular setting underrepresented. Explain the limitation without using it to dismiss an inconvenient result. Ask whether the comments still identify a reasonable question worth testing. If a report suggests that explanations are rushed, a modest observation exercise may be more useful than debating whether the score perfectly represents the entire year. The subsequent evidence can then support or modify the initial interpretation.

## Health probity and constraints

Professional assurance includes honesty about circumstances affecting safe work. Read the health and probity declarations actually required by the local appraisal process rather than answering from memory. Good medical practice requires doctors to take appropriate advice when health may affect their ability to practise safely and to act honestly in professional matters. Having an illness, disability or period of treatment is not equivalent to being unfit to practise. The relevant questions concern its effect on work, the advice obtained, necessary adjustments and whether arrangements protect patients and the doctor. [3]

Appraisal should create space to discuss wellbeing without turning the meeting into an occupational-health assessment. Michael may explain that sustained additional responsibilities have become difficult to combine with recovery time. The appraiser can help him identify the effect and the next

conversation, but cannot determine a medical restriction or rewrite the rota. A useful output records the relevant professional issue and action at an appropriate level of detail. Detailed medical information should be handled through the proper confidential route, not copied indiscriminately into a portfolio because a health field exists.

Distinguish an adjustment already agreed from one still requested. If a doctor says that night work is no longer appropriate, the appraisal should not leave readers uncertain whether this is personal preference, clinical advice or an established employment arrangement. The record can state that occupational-health advice has been sought and a job-plan discussion is pending. It should also explain any immediate arrangement required for safe practice. Waiting for an annual meeting is inappropriate when an urgent health or safety issue needs action sooner.

Probity preparation involves the same discipline. Review professional declarations, indemnity arrangements relevant to the scope and any formal matters requiring disclosure under the applicable process. Check whether an answer covers the whole year and every role. A declaration about the substantive employer may be incomplete if a separate professional activity generated a relevant concern. Where wording is unclear, seek clarification before submission. An uncertain question should prompt a documented enquiry, not an assumption that the least uncomfortable interpretation must be correct.

The portfolio must also distinguish personal conduct from organisational constraints. Lack of equipment, supervision, study leave or reliable data may affect what can be demonstrated or achieved. Describe the constraint specifically, the effect on the work, actions taken and the current position. Avoid two unhelpful extremes: an entirely blameless narrative in which the doctor has no agency, and an entirely personal narrative in which service failures become private development deficits. The useful account identifies what the doctor could reasonably do and what required another decision-maker.

Aisha might report that an agreed supervised opportunity repeatedly disappeared because of rota gaps. A realistic appraisal does not simply mark the objective completed through attendance elsewhere, nor label her unmotivated because it remains unfinished. It examines what experience she obtained, what competence still needs assessment and who can authorise the opportunity. The PDP can record a revised plan and an escalation date. The employer's resource decision remains visible as a dependency instead of being disguised as a promise Aisha cannot fulfil alone.

Finally, ask which constraints need action outside appraisal. Some belong in job planning, some with occupational health, some with a supervisor and some in a formal concern process. Agree who will make contact and what will be shared. This avoids the recurrent problem of a sensitive issue being sympathetically discussed but left without an owner. The appraisal's contribution is a truthful professional account and a sensible route forward. It should make support more accessible while keeping the authority and confidentiality of each process clear.

Be equally precise about recovery. A doctor returning to effective practice after treatment or adjustment should not remain described solely through the difficulty that prompted support. Explain the current arrangements and review point. This gives the reader a contemporary professional picture while preserving the relevant history, and avoids implying either permanent impairment or complete resolution without supporting information.

## Reflection that demonstrates learning

Reflection makes the difference between presenting evidence and understanding it. A useful account shows how the doctor interpreted an experience, what assumptions were tested and what follows. It can concern effective practice as well as difficulty. The joint reflective-practitioner guidance emphasises learning and future action, anonymisation and the distinction between reflection and incident reporting. It also explains that reflective notes do not have blanket legal privilege: a court may require relevant material, although the GMC does not request reflective notes to investigate concerns. Seek advice if disclosure is requested. [65]

A weak reflection says, 'I attended the meeting and learned a lot about communication.' It gives no indication of the question, insight or consequence. A more useful version might explain that the doctor had assumed silence meant agreement, recognised through feedback that a colleague felt unable to challenge the plan, and changed the closing question to invite unresolved concerns. The later review would ask whether colleagues now raise issues earlier. This account is brief, but it contains a movement in understanding and an action capable of being examined.

Use a simple sequence when a blank page makes reflection difficult. First identify the decision or experience, with only the context needed to understand the learning. Then explain what you initially thought and what information challenged or confirmed that view. Describe the alternative understanding, the action taken or planned, and the evidence that will help judge its effect. This is an authoring aid, not a mandatory GMC template.

Different events may need different emphasis; the essential feature is visible reasoning rather than completion of a formula.

Consider Michael's external teaching. His first note says that participants wanted more practical examples, so he added cases. A deeper account asks why the original approach had seemed sufficient. He realises that experienced faculty could supply the missing decision steps mentally, while participants could not. He therefore changes the exercise to reveal those steps explicitly and asks learners to explain their reasoning. The insight is about a mismatch between expert familiarity and the learner's starting point. That understanding can improve other teaching beyond the one revised session.

Reflection need not end in a change of position. Sometimes review confirms that a difficult decision was reasonable on the information available. The learning may concern explaining uncertainty, obtaining support earlier or recognising the limits of retrospective judgement. Avoid rewriting the past as though later information was known at the time. Distinguish what the doctor could reasonably infer then from what became clear afterwards. This makes the account more honest and more useful to future decisions made under similarly incomplete information.

Protect confidentiality by removing unnecessary identifying detail, not merely names. A rare event, precise date, distinctive role and location can identify someone in combination. Describe the professional problem at the level needed for learning and keep factual source records in their authorised systems. Do not include patient correspondence, colleague allegations or screenshots simply because they make the story feel more convincing. The appraiser needs to understand the evidence of learning; that does not normally require a replica of the underlying confidential file.

Avoid both excessive self-criticism and polished self-exoneration. Statements such as 'I must never make another mistake' offer no workable action, while 'the system was at fault' can prevent examination of the doctor's contribution. A balanced account identifies uncertainty, responsibility and context. It may say that a handover system was ambiguous and that the doctor will now verify acceptance of a critical task while seeking a system correction. The individual action is useful, but it does not pretend to solve a problem requiring organisational change.

Before submission, read the reflection without the attached evidence. Can a reader understand the learning and next action? Then read it alongside the evidence. Does it claim more than the material supports? Remove repeated chronology, generic declarations of commitment and unsupported outcomes. Keep the part that shows a changed question, a maintained good

practice or an informed decision. That disciplined editing makes a short reflection stronger and leaves room in appraisal for the discussion that written preparation cannot complete.

Where several reflections end with the same proposed action, examine the repetition. It may reveal a recurring difficulty that needs a stronger response than another promise to communicate better. Consider whether the shared cause is unclear ownership, missing time or an assumption about colleagues' knowledge, and choose an action that addresses it directly.

## The appraisal conversation

Begin the meeting by agreeing its priorities. The portfolio should allow the appraiser to identify questions in advance, but the doctor should also name what needs attention. Michael may want to discuss a sustainable transition from an external role, while the appraiser has noticed that its governance information is incomplete. Both matter. Agree an order that gives difficult or significant topics sufficient time rather than allowing a tour of attachments to consume the conversation. A prepared agenda is a guide, not a barrier to an important issue emerging.

Describe the year's work in ordinary language. Explain changes in scope, what went well, what was difficult and what the evidence cannot yet show. When the appraiser asks for clarification, try to identify the missing link rather than responding with another large document. Is the issue participation, learning, outcome, chronology or an absent role? Each calls for a different response. A precise question can often be answered with a short explanation and one relevant item, whereas indiscriminate additional material may make the uncertainty harder to resolve.

Appraisal can accommodate disagreement. The appraiser may interpret feedback differently or consider an objective insufficiently developed. Ask what evidence or reasoning supports that view and explain your own. Agreement is more likely when both distinguish the underlying observation from its possible meaning. If an issue cannot be resolved, the record should describe the difference accurately and identify the appropriate advice route. Signing an inaccurate summary merely to complete the process creates a problem that may be more difficult to explain later.

The meeting should also notice achievements without making praise its main output. Ask what enabled effective work and whether the conditions remain available. Michael's teaching may have succeeded because preparation time was protected; an expansion without that time could undermine the result. Aisha's early progress may depend on access to a reliable supervisor. Identifying those dependencies helps preserve good

practice. It also gives a development plan a firmer basis than assuming that successful outcomes can be repeated indefinitely through personal effort.

At the end, distinguish the appraisal summary from the next actions. Check that the account represents the whole scope, records relevant discussion fairly and does not imply that an unresolved issue has been settled. Identify which objectives belong in the PDP, which need a separate management or professional conversation and who will initiate them. An appraiser's recommendation to seek support is useful only if the doctor knows which service or person can provide it. Set a reasonable date for reviewing the written output through the local process.

Afterwards, correct factual errors promptly and preserve the final agreed version. Avoid quietly editing the underlying history when a later development changes the position; use a dated clarification through the appropriate system. The appraisal should be a trustworthy record of what was known and discussed at that time. Its value increases when the doctor can return months later and see the reasoning behind an objective, the support it required and the question the next review was intended to answer.

Before leaving, say aloud what you believe has been agreed. This simple check can reveal that an action the doctor heard as optional was understood by the appraiser as necessary, or that a request for clarification was mistaken for criticism. Resolving the difference immediately is easier than interpreting ambiguous wording later.

## A workable personal development plan

The PDP translates the appraisal into a manageable set of intentions. It should arise from actual learning needs, professional responsibilities and chosen development, rather than an obligation to populate every available field. A small number of meaningful objectives is usually easier to pursue than a long collection of aspirations. The appropriate number depends on the work and local process; this handbook does not impose a universal quota. Each objective should explain the intended improvement, the action, how progress will be recognised, the support needed and the review date.

Compare 'Improve teaching skills' with an objective grounded in Michael's appraisal: by the next scheduled course, redesign one session to make clinical reasoning explicit, obtain peer observation and compare learner feedback with the earlier format. This identifies a task and a source of evaluation without claiming that one session will transform educational practice. It also raises practical dependencies: faculty agreement, preparation time and a colleague able to observe. If those are not available, the objective needs revision or an action to obtain them.

A clinical objective can work similarly. Aisha identifies uncertainty about a particular decision within her agreed scope. Her plan is to review the relevant guidance, discuss a series of suitable examples with a supervisor and obtain feedback on her reasoning before the next development review. The objective should not invent a numerical quota unless an applicable assessment requirement supports one. What matters is sufficient evidence for the question being asked. If formal competence assessment is needed, name that requirement and the person authorised to undertake it.

Distinguish activity from completion. Booking a course completes an administrative step; attending completes an educational activity; applying and reviewing learning addresses the professional objective. Not every goal needs all three stages, but the wording should reveal what success means. A plan to understand pension options might appropriately end with obtaining scheme information and qualified advice, rather than a predetermined retirement decision. A plan to explore a leadership role may end in an informed choice not to pursue it. Development can clarify a direction without requiring promotion.

Add a contingency where the objective depends on another party. If supervised experience is not available by the agreed date, Aisha will discuss an alternative arrangement with the educational lead. If access to data is delayed, Michael will revise the evaluation timetable and record the limitation. This turns a foreseeable obstacle into a decision point. It also prevents a year-end judgement based solely on whether a box was completed, when the original plan relied on an organisational action that never occurred.

For each objective, write one sentence explaining why it deserves space in this year's plan. If the answer is only that it sounds professionally admirable, make it more specific or remove it. Ask what would remain difficult, uncertain or unsafe if the objective were not pursued. This test helps prioritise competing ambitions and distinguishes necessary maintenance from optional exploration. Both can be legitimate, but the doctor should know which demands prompt action and which can reasonably wait when circumstances change.

Review the PDP during the year, particularly after changes of role, health or service organisation. Record completed learning, explain abandoned objectives and revise those that no longer make sense. Do not retrospectively pretend that a changed goal was the original plan. At the next appraisal, the sequence should show what the doctor intended, what happened and why the response was reasonable. The final measure of a workable PDP is simple: the doctor can identify the next action without

reopening a complex portfolio, and the later reviewer can see how that action served professional practice.

Chapter 11

# Revalidation

## Licence and revalidation

Revalidation concerns the continuing licence to practise. It is connected to annual appraisal, but the two should never be treated as names for the same event. The doctor gathers information and engages in professional review. The appraiser conducts and records the annual discussion. The responsible officer, or an approved suitable person where applicable, considers the wider evidence and makes a recommendation. The GMC makes the decision. Understanding that chain removes much of the mystery surrounding the process and helps the doctor direct a question to the person who can answer it.

The usual pattern is a recommendation around every five years, informed by annual whole-practice appraisal and governance information. The actual submission date is the one notified by the GMC; it can change. Revalidation demonstrates continued fitness for licensed practice rather than awarding an employment grade, specialist registration or competence in a newly proposed procedure. A favourable decision therefore does not establish that a doctor meets every requirement of a Specialist vacancy. Those decisions require the relevant capability and appointment evidence described later in this handbook. [66]

Begin with the licence because career changes can alter the assumptions underneath it. A doctor may move from a full clinical post to a mixture of teaching, leadership and occasional clinical work. The smaller clinical component does not make professional obligations disappear. Conversely, someone who stops work requiring a UK licence may consider retaining registration without the licence, with appropriate advice about the activities still intended. The choice should follow a description of the future work. It should not be made simply because a revalidation date has become inconvenient.

A useful personal record contains the GMC number, current registration and licence status, recognised connection, submission date and the contact responsible for local revalidation administration. This need not be a complex spreadsheet. Its purpose is to ensure that an employer change, inaccessible email account or misunderstood date does not become a professional problem through administrative neglect. Check that GMC communications reach an address you monitor independently of a single

temporary workplace. Record any confirmed change rather than relying on a conversation remembered differently months later.

The process is sometimes described as a final portfolio inspection. That image is misleading because it encourages the doctor to concentrate all effort near the submission date. Reliable assurance develops through ordinary professional systems: appropriate review of work, timely handling of concerns, annual discussion and follow-through on learning. If those systems reveal a difficulty, action belongs at the time it arises. Revalidation is not designed to store concerns for a five-year reckoning. A doctor who understands this can distribute preparation sensibly and seek help while there is time to resolve a gap.

Nor is revalidation a universal examination of everything a doctor could ever be asked to do. The declared scope matters. If the role expands, the doctor and organisation need suitable development, support and assurance for that expansion. An existing licence remains necessary but does not replace local credentialling, supervision or assessment where these are required. Michael's successful revalidation, for example, would not authorise a clinical activity he has not maintained. The organisation still needs to understand the proposed work and the evidence relevant to it.

This chapter follows the process from connection to decision, including what happens when circumstances disrupt the expected sequence. Its aim is practical confidence, not a guarantee of an outcome. The reader should be able to explain who makes the recommendation, what information is still needed and which next action lies within their control. When a formal notice or disputed decision appears, that same organised account will help a defence organisation, representative or legal adviser provide focused advice instead of first reconstructing an uncertain history.

Use the same terminology when discussing progress with colleagues. Saying that the appraisal is complete, the recommendation is pending or the GMC decision has arrived conveys a specific stage. Saying simply that revalidation is 'sorted' may conceal an important outstanding step.

## Designated body and prescribed connection

A designated body is an organisation identified within the responsible-officer framework. Its responsible officer has defined duties relating to the doctors connected to it. The prescribed connection follows the applicable regulations; it is not an arrangement chosen for convenience. The GMC protocol makes clear that doctors cannot select whichever responsible officer they prefer and responsible officers cannot simply decline a connection established by the rules. Northern Ireland has its own

responsible-officer regulations, alongside the framework applying in England, Scotland and Wales. [67]

For many SAS doctors, the substantive employer provides an obvious starting point. It should still be confirmed rather than inferred from a job title. Multiple employers, agency work, changing contracts, practice outside the NHS or a period between posts can make the answer less straightforward. The GMC's online connection tool asks about the doctor's circumstances and directs the user towards the relevant route. Work through the actual questions with current information; an answer based on the previous year's main job may no longer fit. [9]

Do not replace the tool or regulations with a rough rule such as 'whichever employer pays most'. Some employment relationships have particular significance in the connection hierarchy, and the relevant facts may include the type of organisation and the contractual relationship. The safe practical approach is to assemble those facts, use the official route and obtain clarification where the result is unclear. This is not excessive bureaucracy. Choosing the wrong connection can leave the right organisation unaware of its responsibility while the doctor assumes that arrangements are already in place.

Aisha, the composite Specialty Doctor, provides a simple example. She starts a substantive NHS appointment and is told at induction that the medical director is the responsible officer. She still needs to confirm the designated body recorded in GMC Online, register with the appropriate appraisal arrangements and identify the local contact. These are related but separate actions. Having a portfolio login does not prove that the connection has been recorded. Receiving an appraisal date does not prove that the responsible officer has information about work she undertook before joining.

Michael's mixed career creates a different question. He has a main NHS appointment and external professional roles. Whole-practice appraisal requires information about all relevant roles, but that does not ordinarily mean appointing a separate responsible officer for each. The connected responsible officer needs a sufficiently complete view, including information from other organisations. Michael should therefore identify external governance contacts and explain his scope to the appraisal and revalidation team. Multiple sources of evidence are compatible with a single prescribed connection; the evidence should follow the work rather than multiply recommendations.

If no designated-body connection can be identified, do not assume that revalidation is optional or that a personally selected senior colleague can

simply sign it off. The GMC provides routes involving an approved suitable person and arrangements for doctors without either a responsible officer or suitable person. Doctors in the latter position have additional direct requirements, including an annual return and, when requested, a revalidation assessment. The current annual-return form is a distinct GMC process, not the same as an employer appraisal declaration. Obtain specific instructions from the GMC before committing to a privately supplied appraisal package. [68]

A connection problem should be described in a short factual enquiry. List the organisations, contractual relationships, dates, current medical activities and the result of using the connection tool. Ask who will confirm the prescribed connection and what should happen while clarification is pending. Avoid sending a large unstructured portfolio when the missing information is contractual. Keep the response with the personal revalidation record and update GMC Online as instructed. If employment changes before the issue is resolved, tell the contact rather than allowing the original enquiry to proceed on outdated facts.

Relationships also matter. A conflict involving the responsible officer may require formal arrangements, but it does not give the doctor a general right to move the connection elsewhere. Raise the specific concern through the designated body's process and seek independent advice if necessary. A disagreement about a management decision, an appraisal summary or a whistleblowing issue needs accurate description. The remedy depends on the nature of the conflict and the applicable framework. A new connection should never be treated as a way to leave relevant governance information behind.

The reader's connection finder is therefore a sequence of evidence-based questions. What licensed work am I doing? Which organisations employ or contract with me? What does the official connection route indicate? Does GMC Online show the confirmed position? Who arranges appraisal and receives whole-practice information? What must change when the work changes? Once those questions are answered, the doctor can concentrate on the substance of revalidation rather than repeatedly trying to solve uncertainty through informal reassurance.

Keep the confirmation date beside the answer, so that later changes trigger review rather than unnoticed drift.

## Information used for recommendation

The responsible officer's recommendation draws on more than the doctor's preferred account of the year. The GMC requires consideration of appraisal

participation, supporting information and reflection across the whole practice, and relevant clinical and corporate governance information. Applicable conditions or undertakings and relevant local processes also matter. A recommendation to revalidate means that the responsible officer can make the required declaration on the available information; the appraiser does not make that declaration merely by completing an annual summary. [69]

This wider view explains why a completed appraisal may be followed by a request for further information. The request does not necessarily imply that the appraisal was defective or the doctor is under suspicion. A role may not yet have a governance statement, a previous organisation may not have transferred records, or the responsible officer may need confirmation of an action discussed in the summary. Ask what question the requested item answers. A precise response is more useful than resending every attachment from the appraisal portfolio.

Keep the history intelligible. Record appraisal dates, periods covered, final outputs and any approved interruptions. Note when formal patient and colleague feedback were collected and discussed, and identify the relevant quality improvement activity. These are not boxes to complete in isolation: Chapter 10 explains the learning each category should support. The revalidation overview simply enables the responsible-officer team and doctor to see where the cycle's information sits. It should point to the source records without copying confidential content into a second uncontrolled archive.

Governance information needs context. A complaint that was investigated and resolved should not be described as an unresolved allegation. Equally, a doctor's personal belief that a complaint is unfounded does not establish its formal outcome. Where there is an ongoing process, identify who owns it, what stage it has reached and when information is expected. A neutral chronology helps the responsible officer understand the position without being asked to decide disputed facts from a selective narrative. The doctor can still challenge an error through the proper route.

Consider Michael's external teaching role. His appraisal reflection may explain what he changed in response to participant feedback, while the host organisation separately confirms whether it holds relevant governance concerns. Those records do different work. The positive evaluation cannot substitute for the governance statement, and a statement that there are no recorded concerns cannot demonstrate educational improvement. Together they provide a more complete picture. The same principle applies to

occasional private work, honorary activity and professional roles undertaken for another employer.

Evidence quality is often improved by identifying its owner. An appraisal summary is an agreed record of a discussion; a feedback report comes from a particular collection method; an employer statement has a defined period and scope. Label these accurately. If a document is provisional, say so. If the doctor has written a personal explanation, do not present it as an independent finding. This discipline is especially valuable when several organisations use different terminology for similar records. Clear provenance reduces the risk that an impressive-looking document is asked to answer a question it cannot answer.

The practical readiness review therefore asks whether the information is complete enough, coherent and available to the right person. Does it cover all relevant roles? Are important dates consistent? Are unfinished actions visible? Has reflection been discussed rather than merely uploaded? Are organisational delays being managed? The doctor need not reproduce the responsible officer's evaluation, but should know where a gap exists. Early identification turns an apparently last-minute regulatory problem into a defined administrative or professional task with an owner and a realistic timetable.

If a requested record seems disproportionate or confidential material is involved, ask for the purpose, minimum necessary content and approved transfer route. Seek advice where appropriate. Cooperation does not require indiscriminate disclosure, and a concern about disclosure should be explained promptly rather than expressed through silence. The aim is to provide information that can legitimately support the decision while preserving accuracy, confidentiality and a clear record of how the request was addressed.

When the item is supplied, ask whether it resolves the stated gap. This closes the communication loop and prevents both parties assuming that the other has identified a further problem. Record any remaining question separately with its owner.

## Revalidate defer and non engagement

The GMC protocol identifies three recommendation types: revalidate, defer and non-engagement. The distinction is substantive. A recommendation to revalidate states that the relevant requirements are met on the information available. Deferral concerns an engaged doctor for whom additional time or information is reasonably needed. Non-engagement concerns failure to participate sufficiently without a reasonable explanation after appropriate

opportunities and processes. None should be translated casually into 'pass', 'fail' and 'warning'. Those labels obscure who makes the decision and what the doctor needs to do next. [70]

Where the recommendation is to revalidate, the doctor should retain the resulting GMC communication and note the next notified date. A favourable appraisal summary or an administrator's expectation is not the final GMC decision. Continue ordinary professional maintenance while the process completes. There is no need to manufacture additional evidence simply because the date is approaching, but any material change or request should be addressed. Once the decision arrives, update the personal record and continue the annual routine rather than treating revalidation as permission to stop collecting information until the next cycle.

Deferral changes the submission date; it is not a sanction or a finding of impaired fitness to practise, and does not itself affect the licence. [66] The GMC permits it for an engaged doctor when information is incomplete or a relevant local governance process needs to conclude. Reasonable circumstances include parental leave, sickness, a break in practice or delayed records. Not every break requires deferral if sufficient information exists. The responsible officer must identify what is needed and a realistic plan. Recommendations can be submitted in the 120 days before the submission date, for a proposed period of 120 to 365 days. [71]

The useful response to proposed deferral is therefore a set of practical questions. What precise information is missing? Why is it necessary? Who can provide it? What must the doctor do, and by when? Which part depends on an organisation? How will progress be reviewed? A vague assurance that there will be 'more time' is insufficient. The revised timetable should lead to an informed recommendation. Deferral should not leave the doctor guessing whether to repeat an appraisal, collect another survey or wait for an investigation that someone else controls.

Suppose Aisha's previous employer has not transferred a required governance record. She has completed appraisal, engaged with requests and provided the information she holds. A plan might identify the transferring office, the request already made, the expected response and a review date. This is quite different from Aisha declining to disclose a role or repeatedly ignoring requests. The missing document looks similar on a checklist, but the circumstances and response are different. A sound process examines that difference rather than treating every absence as non-compliance.

Non-engagement can put the licence at risk. The GMC criteria require insufficient participation despite support and opportunity, no reasonable grounds or appropriate deferral basis, and exhaustion of reasonable local

attempts to resolve matters. A recommendation starts a regulatory process rather than removing the licence immediately. The current protocol gives the doctor 28 days to respond to the GMC's risk notification; a subsequent withdrawal decision carries a 28-day appeal period. A timely appeal prevents removal until the appeal outcome. The actual notice and qualified advice should govern the response, because deadlines are consequential. [72]

If such a notice arrives, act immediately. Preserve the letter, establish the response deadline and contact the defence organisation or appropriate adviser. Assemble a chronology of invitations, responses, technical failures, health-related communications, agreed adjustments and material already submitted. Distinguish a reasonable explanation from a general expression of distress. If the doctor can now provide missing information, say what it is and when it will be supplied. Challenging an inaccurate allegation of non-engagement and engaging with the outstanding process can proceed together.

Silence is particularly damaging because it prevents the relevant people from understanding circumstances that may be reasonable. A doctor overwhelmed by illness or an employment dispute may need help with communication; that need should be raised through an appropriate representative or support route. Conversely, repeated promises without action may not resolve the problem. The plan needs a credible next step and a date. Do not assume that an appeal against an unrelated employment decision suspends revalidation obligations or changes the GMC deadline unless the GMC confirms the position.

Repeated deferral also needs careful handling. It is not an unlimited holding arrangement. If the agreed information remains unavailable, the reason and revised proposal need early discussion with the responsible-officer team. A doctor should show the actions taken and identify what remains outside personal control. Further deferral requires exceptional circumstances and early discussion between the responsible officer and GMC employer liaison adviser. An unresolved organisational delay, a new exceptional circumstance and continued failure to engage are different situations. None can be inferred reliably from elapsed time alone. [71]

Whatever the proposed recommendation, ask for an intelligible explanation and retain the final communication. The most useful personal summary states the current position, the decision-maker, the outstanding action and the next date. That short record is more protective than a comforting label. It allows the doctor to tell an employer or adviser accurately what has happened, without describing deferral as disciplinary

failure or treating an initial recommendation as a decision already made by the regulator.

A doctor concerned about the reputational meaning of deferral can ask how it will be recorded locally and who needs to know. The explanation should match the actual reason. An administrative information delay should not be described through language suggesting a finding about clinical performance that nobody has made.

## Career breaks health absence and missing appraisal

An interrupted working year does not fit neatly into a routine annual timetable. The GMC's overarching supporting-information guidance explicitly recognises clear and reasonable circumstances preventing annual appraisal. These should be discussed and agreed with the responsible officer or suitable person. Approved missed appraisals do not have to be retrospectively caught up, and five completed appraisals are not an invariable prerequisite for revalidation. The question is whether the available whole-practice information and engagement support the recommendation, not whether every calendar year contains an identical administrative event. [58]

Consider a separate composite doctor, Nadia, a Specialty Doctor in Wales returning after parental leave. Her submission date falls several months after return, and her appraisal history includes an approved interruption. She worries that she must arrange two appraisals quickly to replace the missed year. Her first task is to obtain the written record of the approved absence and discuss readiness with the revalidation team. The appropriate outcome depends on the information already available and what remains needed. It cannot be determined by adding the number of meetings alone.

Nadia prepares a chronology of work, leave and return. It identifies the last appraisal, the period covered, earlier feedback and quality improvement, and the date on which her current responsibilities resumed. She also records any change in scope or support on return. This allows a focused conversation. Does existing feedback remain appropriate within the cycle? Is there sufficient current information? Does a particular category need further work? If additional time is justified, the plan should name the missing item rather than instruct her vaguely to 'build up the portfolio'.

Sickness absence requires the same distinction between professional evidence and personal medical detail. The revalidation team needs enough information to understand the interruption and necessary arrangements, using appropriate confidential channels. It does not follow that detailed

treatment records belong in appraisal attachments. A supported return may involve occupational-health advice, altered duties and a period of supervision or updating. Describe the effect on the professional role and the relevant plan. Chapter 10 explains how health and development can be discussed without making illness a proxy for professional failure.

A career break abroad raises an additional issue. UK revalidation normally relies on information from UK practice. The GMC allows a responsible officer or suitable person to consider overseas information if satisfied that it provides the required assurance, but maintaining a licence on wholly or substantially overseas evidence is exceptional. Discuss intended overseas practice before departure, including whether a UK licence is required for the proposed work. Do not assume that an overseas employer's annual assessment automatically substitutes for UK requirements. [73]

For any planned break, establish what will happen to the connection, appraisal arrangements and access to records. Obtain final outputs through authorised routes before an account closes. Agree how the organisation will contact the doctor, whether any appraisal is expected during the period and when the plan will be reviewed. If the return date changes, notify the relevant team. A short contemporaneous agreement is much easier to use than reconstructing whether a manager's reassuring comment was intended as formal approval for a missed appraisal.

Missing appraisal without an agreed interruption is a different problem and needs prompt explanation. The doctor should identify why the meeting did not occur, what attempts were made and how it can now be addressed. A cancelled appraiser appointment, unresolved allocation problem and refusal to participate are not equivalent circumstances. Present the evidence without exaggeration. If responsibility is shared, describe both the organisational failure and the action the doctor took. The goal is to restore a workable process, while preserving an accurate account if a later judgement depends on it.

After return, choose development according to the actual work and time away. A familiar post may have changed systems, personnel or pathways. Extensive previous experience does not remove the need for reorientation, but neither does a break erase established capability. The readiness discussion should identify what needs updating and how it will be supported. Revalidation then sits within a coherent return plan, alongside safe duties, appraisal and wellbeing, instead of appearing as an isolated deadline imposed on a doctor still trying to understand the changed service.

## Moving organisation or nation

Moving employer creates two related tasks: establish the new connection and transfer enough professional information for continuity. A new contract, a new appraisal platform and a new responsible officer may take effect through different administrative steps. None should be assumed complete merely because employment has begun. The doctor should confirm the leaving and joining dates, identify both revalidation teams and check the resulting position in GMC Online. The submission date does not simply restart because a career move feels like a new beginning.

The GMC protocol expects responsible officers to consider the whole practice and arrange access to information from relevant organisations. Its information-sharing principles support continuity across systems. For the doctor, the practical implication is to facilitate an accurate transfer, identify missing material and provide the receiving team with a clear account of the work. An organisational transfer should include relevant concerns and their status as well as favourable appraisal outputs. Changing employer is not a method of resetting the professional record. [74]

Before departure, ask which documents will transfer directly and which the doctor should retain or supply. Commonly useful records include final appraisal summaries, PDPs, relevant feedback outputs and confirmation of appraisal interruptions or other agreed arrangements. Governance information may travel between authorised organisational contacts rather than through the doctor personally. Respect that distinction. Do not export patient records or investigation files into a private account to ensure that 'everything is saved'. Retention and transfer must use the appropriate information-governance arrangements.

Aisha's move from one NHS employer to another illustrates the timing problem. Her last appraisal covered a period ending before the move, while the next is due after she joins. The receiving organisation needs to understand both periods. She prepares a scope chronology and provides the final summary through the approved process. If her previous portfolio is no longer accessible, she contacts its administration team rather than trying to recreate an appraiser's report from memory. Her own explanatory note remains labelled as such and does not impersonate an official output.

Cross-border moves add delivery differences without changing the fact that the GMC regulates the licence. Wales uses MARS for medical appraisal, and Scotland uses SOAR. England and Northern Ireland require the receiving organisation's operational arrangements to be confirmed. The Department of Health Northern Ireland publishes its revalidation framework and responsible-officer material; this should not be replaced by assuming an

English local policy applies. The doctor needs a transfer plan that distinguishes regulatory continuity from the practical work of entering a different appraisal system. [19][17][18]

Close to a submission date, notify the receiving team early. Ask who will make the recommendation, what information is available and whether any transfer delay affects readiness. An employer move does not itself prove that deferral is needed, and it does not justify promising revalidation before the responsible officer has reviewed the record. A short joint clarification between the organisations may resolve the uncertainty. Keep the doctor-facing outcome in writing, particularly if an appraisal date or information deadline changes as a result.

The handover should also capture unfinished professional actions. If an improvement project continues after the doctor leaves, record the contribution completed and who owns later evaluation. If a complaint remains open, identify the responsible organisation and contact route. If a PDP objective depends on experience unavailable in the new post, revise it transparently at the appropriate review. Continuity does not mean carrying every old objective unchanged into a different job. It means preserving the history and making deliberate decisions about what remains relevant.

After arrival, check the transfer rather than assuming that a sent email equals completion. Has the new team received the final outputs? Can it identify the prior period and any interruption? Is the connection correct? Does the next appraisal cover the intended scope? Are external roles still declared? This final reconciliation often takes little time when planned early. It prevents the first warning of an incomplete transfer arriving shortly before a recommendation is due, when the former contact may have moved and access to old systems may be harder to restore.

Retain the receiving team's acknowledgement with the transfer checklist. It provides a clear starting point if information is later reported missing or a different period of practice needs clarification.

## When concerns overlap

Revalidation can coincide with a complaint, employer investigation or GMC fitness-to-practise process, but it does not replace those procedures. A recommendation should not be used to introduce concerns that ought to be raised through the appropriate route. The GMC distinguishes an ongoing local governance process relevant to recommendation from its own fitness-to-practise investigation; the latter has separate handling arrangements. Doctors who retain a licence should continue engaging with revalidation as

far as possible, including complying with applicable conditions or undertakings. [75]

The first practical task is to draw a chronology with separate columns or clearly labelled entries for each process. Record the employer review, any regulator communication, appraisal dates and revalidation requests. Identify the decision-maker and deadline for each. A letter from an employer's investigator may require a factual response, while the appraisal asks for reflection and the responsible officer seeks the status of the investigation. These are related subjects, but submitting the same narrative everywhere can create confusion and unnecessary disclosure.

Seek advice early about formal statements. A defence organisation can help distinguish factual evidence, reflection and a response to an allegation. An employment representative may be needed for contractual or disciplinary issues. Explain to each adviser which other processes are running. The doctor's account should remain consistent in its facts, but the purpose and appropriate content of each document may differ. Do not turn an appraisal note into an unsupported admission merely because the doctor wishes to demonstrate insight, or use a defensive legal narrative as the entire account of learning.

An unresolved allegation should retain its correct status. Suppose a complaint concerns communication during a difficult service episode. The doctor may already have identified a useful improvement while disputing part of the factual account. Both can be stated. Learning does not require invention of a finding that has not been made. Equally, the absence of a final finding does not prevent reasonable action to improve practice or reduce risk. A careful record separates what is alleged, what is established, what has changed and what awaits determination.

Public-interest concerns require particular care if the doctor is also being described as non-engaging. Preserve the chronology and seek independent advice about the appropriate route. The GMC protocol requires responsible officers to involve their employer liaison adviser in specified circumstances involving public-interest concerns and proposed deferral or non-engagement. The doctor should neither assume that raising a concern removes ordinary revalidation duties nor accept an unexplained conflation of whistleblowing, employment disagreement and professional non-participation. These are different questions requiring evidence. [67]

The safest personal method is active, documented engagement within appropriate advice. Respond to requests, clarify uncertainty, ask for reasonable support and maintain the relevant professional activities. If a restriction or health circumstance limits what can be done, explain it

promptly through the correct channel. Keep the next action visible for each process. Chapter 13 develops the handling of formal concerns in greater depth; here the essential point is that a difficult parallel process should be managed explicitly rather than allowed to make the revalidation record incomprehensible.

Support should include the person as well as the paperwork. A trusted colleague can help organise a chronology or identify a missed communication, while professional advisers address the formal issues. Agree what assistance is useful and preserve confidentiality; informal support should not become an uncontrolled circulation of sensitive documents.

## Personal readiness timeline

A readiness timeline should make preparation routine while accommodating the actual GMC date. At the beginning of a cycle, confirm the connection and record the decision and new submission date. Review the scope and plan activities that need lead time, particularly formal feedback and substantial improvement work. At each annual appraisal, examine learning, update declarations and identify what remains outstanding across the cycle. The timetable is a working aid, not a claim that every doctor must follow an identical five-year sequence.

During the early and middle years, test whether evidence collection represents the work. A new clinical role, external appointment or change in patient population may require a different feedback approach. A project may finish earlier than expected or fail to produce usable evaluation. Adjust the plan while there is time. Schedule periodic brief reviews of the evidence map, rather than a large annual attempt to remember everything. The purpose is to preserve learning and identify dependencies, not to turn every ordinary working day into a documentation exercise.

As the final year approaches, ask the local team what readiness review it undertakes and when it needs information. Reconcile appraisal history, formal feedback, quality improvement, scope and governance records. Check that important material has been discussed where required, not merely collected. If a gap remains, define it precisely and agree the action. Do not wait for the last appraisal to discover that an external organisation needs several months to provide a statement or that a feedback exercise requires an accessible alternative method.

Near the submission date, keep communication simple. Confirm that the responsible-officer team knows about any material change and can obtain the information it has requested. Record the expected next step without

treating an anticipated recommendation as a completed decision. If deferral is proposed, keep the action plan and monitor its dependencies. If a formal warning or adverse notice arrives, use its actual deadline and obtain advice immediately. A personal diary entry should support, never replace, reading the regulator's communication.

A practical final check uses three short headings in a private working note: complete, awaiting another person, and action for me. Put only genuinely outstanding items under the last two. Add dates and remove items when resolved, retaining the underlying records elsewhere. This keeps preparation manageable during busy clinical periods. It also makes a request for help specific: the doctor can identify the blocked item and required decision instead of reporting only a general feeling that the whole process is becoming unmanageable.

After the GMC decision, retain the notification and update the timeline. Review what made the process easy or difficult. Perhaps external roles need better governance contacts, the annual scope map needs a fixed review date or a change of email caused avoidable delay. Improve that small part of the system. The purpose of readiness is not to create a second career in administration. It is to keep professional work, evidence and the relevant decision-makers connected well enough that the doctor can explain the position accurately at any point.

Chapter 12

# The professional portfolio

## Portfolio purpose before platform

Ravi, a composite senior Specialty Doctor working in England, had completed annual appraisals conscientiously for many years. His electronic portfolio contained course certificates, reflections, appraisal summaries and personal development plans. When a Specialist vacancy appeared, he expected this material to provide most of his application evidence. The person specification asked for examples of independent clinical judgement, improvement, education and leadership. Ravi could describe considerable experience in each area. Finding documents that demonstrated his contribution was much harder. His portfolio recorded what he had discussed, but often not the work on which the discussion rested.

Nothing in this situation establishes that his appraisals were deficient. An appraisal conversation and a competitive appointment answer different questions. A useful reflection may explain learning without documenting every activity that a recruitment panel wants to assess. Equally, an impressive application example may cover only a small part of the doctor's whole practice. The mistake is expecting material prepared for one decision to satisfy another decision automatically. The portfolio needs a common evidence base, with a separate selection and explanation for each purpose.

Begin by naming the decisions you expect to face. These might include next year's appraisal, a contractual pay progression review, a job plan discussion, a Specialist application, an educational appointment or preparation for specialist registration. Put the actual decision beside its decision-maker, timetable and governing requirements. This creates a practical brief for the portfolio. A folder called career development is less useful than knowing that an application will require evidence of supervising colleagues and that your current records demonstrate teaching delivery but not educational supervision.

The GMC's Portfolio Pathway is a distinct application route to registration. Its guidance directs applicants to the curriculum and specialty specific guidance for the relevant specialty. Applicants should therefore use those requirements to design a dedicated application map; an ordinary professional portfolio is only a possible source of material for it. The employment title Specialist has a different meaning and decision process.

Keeping these purposes separate at the beginning prevents a large amount of later reconstruction.[8]

The platform comes after this analysis. An employer may require a particular appraisal system, and a regulator or recruiting organisation may specify how material must be submitted. Those requirements govern the relevant submission. They do not require every element of your professional history to be stored in the same place. A maintained index can connect authorised evidence held in different systems without creating uncontrolled copies. Think of the index as a finding aid with a brief explanation of relevance, rather than as a warehouse containing everything you have encountered.

Ravi therefore starts with two immediate purposes: preparing his next appraisal and assessing readiness for the advertised Specialist role. He retains the person specification with its publication date, separates essential from desirable requirements and identifies the evidence requested at application and interview. He does not label himself eligible merely because every row contains a file. He asks whether each item supports the particular requirement and whether he can explain its limits. Several rows remain incomplete; that is useful information rather than an administrative failure.

A workable portfolio should answer three everyday questions quickly. What have I done? What evidence may I lawfully use to demonstrate it? What does that evidence justify saying? These questions remain useful when software changes or a career moves between nations. They also make the portfolio proportionate. A doctor preparing no immediate application does not need to organise every working day as if an assessor were about to examine it. The aim is reliable professional memory, with enough structure to support foreseeable decisions and enough restraint to remain maintainable alongside the work itself.

There is a useful stopping rule: if you cannot name a foreseeable professional use for an item, pause before collecting it. This does not mean discarding required records. It means resisting the habit of expanding a personal portfolio merely because storage space is available and the document looks impressive.

## The core evidence index

The core index brings your evidence into a consistent view. It can be a simple document or spreadsheet in an approved location. Begin with a scope record showing each professional role, its dates, organisation, responsibilities and working pattern. Distinguish the substantive post from additional appointments, occasional work and external responsibilities. This

gives later readers the context needed to understand individual items. A teaching record means something different when it concerns one invited session, a recurring departmental commitment or leadership of an entire programme.

For each evidence item, record a short identifier, descriptive title, activity dates, your role, the source location and the purpose it may support. Add the document's status, such as draft, approved or superseded, and whether an appropriately prepared copy is available for sharing. Include a brief note of any restriction: organisational permission needed, identifiers requiring removal, verification outstanding, or available only through a named department. These fields prevent the common discovery, days before submission, that an impressive document cannot actually be used in its present form.

Use identifiers that survive changes in folder names. QI2026A might identify a specific improvement project, with separate linked records for the proposal, baseline summary, approved change and follow-up report. The identifier need not reveal patients, sites or confidential project details. A file title such as QI2026A approved summary September is more informative than final version new. Keep the original date and the date of any permitted derivative copy clear. Do not make an older activity appear current by giving its summary today's date without also recording when the work occurred.

Organise the index around the work you need to describe. Useful areas include scope and appointments; clinical practice; learning; improvement and governance; feedback; education; leadership; research; and professional recognition. These are practical navigation headings, not a new regulatory framework. Some doctors will have little research activity; others will need detailed research governance records. A section should reflect actual work and future requirements, rather than pressure the reader into collecting evidence for a role they do not hold. Empty categories can simply be marked not applicable with a reason.

Within clinical practice, an approved summary of scope, appropriate activity information, assessments and peer discussion may collectively explain what you do. Within education, distinguish planning, delivery, supervision, assessment and evaluation. Within leadership, keep the appointment or agreed remit separate from evidence of decisions and results. A role description shows intended responsibility; it cannot establish that all intended outcomes occurred. Recognition, such as an appointment or award, belongs in the record but should not replace the evidence of capability it is being used to support.

For appraisal, the GMC identifies six categories of supporting information: continuing professional development, quality improvement activity, significant events, patient or service-user feedback, colleague feedback, and complaints and compliments. Their collection and discussion sit within consideration of the whole scope of practice. Your personal headings should allow relevant information to be selected into that framework without forcing every document into only one category. The fuller appraisal method is in Chapter 10; the present task is making its underlying material retrievable.[76]

Ravi's first useful index entry concerns a teaching programme he coordinated. It records the period, intended learners, his agreed role, the programme timetable, an authorised aggregate feedback summary and the location of the educational lead's confirmation. It also records what is missing: no follow-up evaluation of whether the revised sessions addressed the original learning need. The entry supports an account of programme coordination and responsive teaching. It does not yet support a claim that the programme improved clinical outcomes or that Ravi supervised every participating learner.

Give each item a short explanation of its relevance. Two sentences are normally more useful than several tags without interpretation. For example: this approved report records my analysis of the baseline problem and the team's decision to test a revised process; the subsequent evaluation is a separate item and remains incomplete. A future reader, including your future self, can then understand why the document was retained. This is particularly valuable when one project spans several appraisal years or changes leadership halfway through.

Finally, test retrieval rather than admiring the structure. Choose an actual question, such as finding evidence of how feedback changed your teaching, and time how long it takes to assemble a coherent answer. If you repeatedly open irrelevant files, improve the titles or explanations. If the answer depends on a colleague remembering an event, record the need for contemporaneous confirmation. The index is working when it makes an honest answer easier to produce, not when every possible column has been completed.

Keep a short guide to your own abbreviations. A code that seems obvious now may be meaningless after a change of specialty or employer. A reader should be able to understand the index without knowing your department's informal names for meetings, pathways or responsibilities.

## Primary and secondary evidence

Evidence is stronger when it brings the reader close to the work being claimed. In this chapter, primary evidence means material that directly records or demonstrates the relevant activity: an approved report you helped produce, a documented assessment, an authorised activity summary or a teaching programme with evidence of your contribution. Secondary evidence describes, interprets or reports that activity: a CV statement, reflective account or appraisal summary. These are practical distinctions for evaluating a claim, not a substitute for any definitions used by a particular application scheme.

Secondary evidence has an important purpose. It explains context, brings separate records together and shows your understanding of experience. A reflection may be the best evidence of how you interpreted feedback, although it is not independent proof that the underlying activity occurred as described. Similarly, an appraisal summary can establish what was discussed and agreed at that appraisal. Its authority is narrower when used to prove a clinical capability that the appraiser did not assess directly. The question is always what the document actually demonstrates.

Ravi's appraisal summary says that he contributed substantially to an improvement project. That supports the fact that the project featured in his appraisal, but leaves several recruitment questions unanswered. What was the problem? What did Ravi do? Who else contributed? What changed? The primary records may include the approved proposal, minutes assigning responsibilities, an anonymised aggregate analysis and the report of the tested intervention. An explanation connecting these documents is then more persuasive than repeating the appraisal's favourable description in larger type.

No document is primary evidence for every claim made about it. An attendance certificate directly supports attendance under the issuing body's arrangements. It is weaker support for application of learning and may say little about competence. A course assessment records performance in that assessment, within its scope. A letter from a service lead may directly confirm an appointment and describe observed practice; a generic endorsement of excellence does not establish every element of a detailed person specification. Specificity matters more than the prestige of the heading.

Independent confirmation should identify what the confirmer knows and how they know it. A colleague who observed you leading an improvement meeting can describe that observation. They should not be asked to certify data they have never examined or practice from years before they joined the

service. Drafting factual details for checking can assist a busy colleague, but the final account must remain theirs to correct and approve. The portfolio should never convert a courteous signature into apparent validation of unsupported claims.

For a Portfolio Pathway application, verification is a formal part of the GMC process. Its verification guidance specifies who may verify different records and requires an accurate account of the work at the institution concerned. Employment records have particular provisions, so one generic signature is not a universal solution. Ordinary managerial endorsement should not be assumed to satisfy the application requirements. Identify the correct roles before collecting signatures, and use the dedicated application guidance when that route becomes an active objective.[80]

Where original evidence is unavailable, say so and examine what can legitimately be reconstructed. An authorised retrospective confirmation may explain a former role, its dates and the basis for the statement. It should be labelled as retrospective, with uncertainty acknowledged. Do not create minutes for a meeting that was never minuted, reproduce a lost assessment as if it were the original, or turn recollection into an apparently contemporaneous record. An evidence gap is inconvenient; a misleading reconstruction creates a much more serious problem.

The practical rule is to pair assertion with support and interpretation. State the claim narrowly, identify the best available underlying record, and explain your contribution and learning. Where support is partial, qualify the claim or obtain additional evidence. This approach allows a portfolio to remain confident without becoming inflated. It also helps the reader recognise when the missing element is a document, when it is independent observation and when the required experience has not yet been obtained.

When reviewing your own draft, underline each strong verb. Led, designed, assessed and implemented make different claims. Ask which underlying record supports each verb and whether a colleague involved in the work would recognise your description as fair.

## One item several uses

One well-documented piece of work can support several professional conversations, provided each conversation receives the evidence appropriate to its purpose. The efficiency lies in maintaining a reliable underlying record, not in sending the same large bundle everywhere. Begin with the activity and the claim it supports. Then ask what each decision-maker needs to know, what standard applies and what information should

remain outside that submission. The resulting selections may overlap, but their explanations will differ because the questions being answered differ.

Consider a composite project in Ravi's service concerning the communication of outstanding investigation results after discharge. The project is illustrative, not a clinical protocol. Ravi helped define the problem, worked with nursing and administrative colleagues on a revised communication process and presented an aggregate evaluation to the governance group. His evidence includes an agreed remit, approved project summary, contribution record and follow-up discussion. The underlying patient information remains in the organisation's authorised systems; the portfolio holds only material approved for the relevant professional use.

For appraisal, Ravi might select a short account of why he became involved, what he learnt about responsibility at transitions of care and how his practice changed. He can discuss uncertainty in the findings and the next development objective. The appraisal selection needs to remain proportionate to the whole scope of his work. It should not occupy the entire submission merely because the project generated many documents. The same year may also require meaningful attention to clinical learning, feedback, additional roles and other supporting information.

For job planning, the most relevant evidence may be different. Ravi can identify the work required for data review, meetings, process design and evaluation, together with the recurring duties that remain after the project. This supports a discussion about time, responsibility and service expectations. An encouraging outcome does not itself determine the number of programmed activities to allocate. The job planning conversation needs evidence of the work and its resource requirements, using the contractual approach explained in Chapters 6 and 7.

For a pay progression review, the project may help demonstrate progress against a specifically agreed objective. Ravi should show the objective's wording, the contribution expected of him, relevant dependencies and what was achieved within the review period. If the objective was only partly completed because an agreed data extract arrived late, the evidence should preserve that sequence. A later successful result should not erase the earlier constraint. Whether the material satisfies progression requirements remains a question for the applicable contract and process discussed in Chapter 8.

For a Specialist application, Ravi could use the project to illustrate leadership, collaborative working or improvement capability where these appear in the actual person specification. His account should make clear whether he initiated, led, coordinated or contributed to each stage. An interview answer may need a concise description of a difficult decision and

what he would do differently. The application is stronger when the panel can distinguish his personal judgement from the team's overall achievement. It is weaker when every verb implies that one doctor delivered the entire change.

For a Portfolio Pathway application, the first question is whether and how the project addresses the relevant specialty outcome. The GMC advises applicants to group and label evidence clearly, follow specialty naming conventions and cross-reference rather than submit the same item repeatedly. A project that is useful evidence for one outcome may need complementary material for another. Its inclusion should arise from the specialty map, rather than an assumption that evidence accepted in a recruitment exercise will satisfy a regulatory assessment.[8]

The multi-purpose mapper can therefore be brief. Record the item's identifier, the proposed use, the precise claim, the requirement being addressed and any additional evidence or permission needed. Keep a record of the version actually submitted for each purpose. That prevents later confusion when a short appraisal reflection and a longer application explanation draw on the same work. Neither should contradict the other, although their emphasis legitimately differs. Reuse is successful when it reduces duplication while preserving the integrity of each decision.

It is also acceptable not to reuse an item. A sensitive reflection may belong in the appraisal process without helping a recruitment application. A detailed organisational report may be unnecessary when an authorised summary answers the question. Selection is a professional judgement, not an obligation to extract maximum promotional value from every experience.

An item can also change status. A draft that was adequate for discussing an idea may need replacement by an approved report before it supports a formal claim.

## Evidence quality and impact

Evidence quality depends on the relationship between the claim, the material and the conclusion. Six questions provide a useful test. What am I claiming? What supports it? What was my contribution? What happened? What did I learn? What should happen next? These questions are an authoring method, not an official scoring system. They help the reader move beyond accumulating activities towards explaining professional judgement. They also expose unsupported leaps, especially between participating in work and claiming responsibility for an outcome.

Start with the claim. Coordinated a departmental teaching programme is more precise than transformed education. Reviewed a communication process and tested a change is more defensible than eliminated clinical risk.

Ambitious language often hides information that would make the work more persuasive: the difficulty of agreeing the problem, the judgement involved in choosing a measure, or the decision to abandon an intervention that created new burdens. Accuracy does not require modesty about genuine responsibility. It requires words that correspond to what the evidence can demonstrate.

Next examine the measure. In an illustrative evaluation, suppose a defined documentation field was completed in 24 of 40 records before an intervention and 34 of 40 afterwards. Completion increased from 60 per cent to 85 per cent, a rise of 25 percentage points. It would be incorrect to describe this simply as a 25 per cent relative improvement. More importantly, the finding concerns completion of that field in those samples. It does not establish a reduction in harm, improved patient understanding or sustained performance throughout the service.

The interpretation needs the sampling method, period and limitations. Were the same inclusion criteria used? Were missing records excluded? Did the case mix or staffing change? Did the team measure work transferred to another group? Small improvement projects often cannot isolate causation confidently, but they can still provide useful learning. A candid account might conclude that documentation improved in the sampled records after the change, while acknowledging that another operational change occurred during the same period. This is stronger reasoning than presenting temporal association as proof.

Ravi's contribution also needs to be visible within the team. He might have designed the initial measure, facilitated agreement across professions and presented the findings, while another colleague organised data collection and the ward team implemented the change. His portfolio should credit those contributions. If he later led the follow-up after the original coordinator left, explain the change in responsibility and dates. Shared achievement does not diminish his evidence of leadership; fair attribution demonstrates that he understands how the work was actually delivered.

Negative or mixed findings can produce strong evidence of judgement. Suppose the new process improved documentation but added an unmanageable task at a busy handover. The team's decision to simplify the process, test a smaller change or pause implementation may demonstrate more professional maturity than continuing to chase the original target. Ravi should retain the reasons for the decision and the subsequent review. A portfolio that contains only successes can become less credible if it gives no indication of uncertainty, trade-offs or changes of mind.

Triangulation means using different kinds of relevant evidence to examine the same claim. For teaching, a programme and attendance record show delivery; learner feedback offers one perspective on experience; observation by an educator can address teaching practice; and later evaluation may examine a defined learning outcome. These sources should not be treated as interchangeable or automatically independent. Ten enthusiastic comments copied into three documents remain the same comments. The aim is to understand the activity from complementary perspectives rather than increase the apparent volume of support.

Recency also has meaning rather than one universal expiry date. An older qualification may remain an important credential, while a claim about current procedural practice needs current support appropriate to the role. A historic leadership project can demonstrate experience but may not show how you now manage a changed service. Use the relevant application requirements where they prescribe evidence periods. Otherwise ask whether the document still answers the question being asked and whether later developments should accompany it. Never discard valuable career history merely because it is not recent enough for one particular submission.

End each important evidence account with the next step. It may be repeating a measure, arranging peer observation, revising a development objective or handing responsibility to a successor. This turns the portfolio into a record of continuing practice. It also gives the next review something concrete to revisit beyond the fact that an activity took place.

## Confidentiality anonymisation and security

A professional portfolio is not an alternative clinical record. Its purpose is to support professional review and development, usually without retaining identifiable details about patients or colleagues. Start with the least sensitive material capable of answering the professional question. An authorised aggregate summary may establish your contribution to a project more effectively than copies of patient records. Where an application legitimately requires more detailed evidence, use its instructions and the organisation's information governance arrangements before extracting or sharing anything. Access for clinical work is not unrestricted permission for later personal use.

Removing a name is only the beginning of considering identification. A rare condition, an exact date, a small service, an unusual family event and a clinician's role can together make a person recognisable. The ICO distinguishes anonymisation from pseudonymisation: replacing identifiers with a code does not necessarily take information outside data protection law when a person can still be identified using additional information. Its

guidance requires consideration of identifiability in context. A label such as anonymous or Patient A does not settle the issue.[77]

Consider a reflection about communication with a family. The learning may depend on uncertainty, conflicting expectations and the timing of a senior discussion. It may not depend on the patient's age to the year, named hospital, exact admission date or unusual occupation. Removing unnecessary details can preserve the professional reasoning while reducing recognition risk. Do not silently change factual details in material presented as a real evidential record. Instead, omit or generalise what is unnecessary in the reflective account, and describe any illustrative teaching case explicitly as composite.

The joint reflective practitioner guidance advises focusing reflective notes on learning and future plans, with anonymisation of those involved. Reflection should not be confused with the clinical record or the formal documentation of an incident. An appropriate reflective account can therefore be concise about events while explaining your reasoning in depth. When a complaint or investigation is active, obtain relevant professional advice about the required response and records; do not use the portfolio as a private substitute for the formal process.[65]

Digital redaction requires particular care. A black rectangle placed over text in a document may leave the underlying text recoverable. Comments, tracked changes, filenames, embedded spreadsheets, photographs and document properties can disclose information outside the visible paragraph. Use the organisation's approved method for producing a shareable derivative, then inspect the actual exported file. If a document cannot be made suitable without destroying the evidence it is intended to provide, seek an authorised alternative, such as an aggregate report or a properly scoped verification statement.

Security includes keeping information accurate and available as well as preventing unauthorised access. ICO guidance takes a risk-based approach to technical and organisational measures, including access controls, recovery and appropriate encryption. For a doctor maintaining a portfolio, the practical implication is to use approved systems and follow their rules for devices, sharing and backups. A familiar personal cloud account is not automatically an approved destination for organisational information. Password protection alone does not establish that sharing is authorised or that the recipient needs every document.[78]

Before using a digital writing assistant, online converter or browser tool, establish what information the service receives and whether its use is permitted for that material. Do not paste patient-identifiable, confidential

employment or investigation material into an unapproved service to obtain a better summary. A safer writing task uses an abstract question or a genuinely non-identifying draft. Whatever assistance is used, you remain responsible for the accuracy of the account, the validity of its evidence and the appropriateness of its disclosure. Fluent wording cannot supply missing experience.

Retention should be deliberate. The ICO's storage limitation guidance does not set a single retention period for every kind of personal data; retention depends on a justified purpose and should be reviewed. Consequently, neither keeping everything forever nor deleting everything after an appraisal cycle is a sound universal portfolio rule. Follow applicable organisational schedules and any legal or professional advice concerning particular records. Separate enduring personal credentials from sensitive operational material, and record a review date where the continuing need is uncertain.[79]

Where a complaint, investigation or legal matter requires records to be preserved, obtain advice before routine disposal. Portfolio housekeeping must respect any applicable preservation requirement.

If information is sent to the wrong person or an unsafe copy is discovered, act promptly through the employer's reporting process. Preserve the facts needed to explain what happened and follow advice on containment; do not assume that recalling an email removes the disclosure. The aim is to reduce harm and permit a proper assessment. Everyday portfolio housekeeping should make such incidents less likely by limiting copies, checking recipients and keeping a clear distinction between the working source and the version authorised for submission.

## Gaps and opportunity requests

An evidence gap can mean several different things. The work may have been done but not documented. It may have been documented in a form that cannot be shared. The evidence may be available but too narrow for the proposed claim. Or the experience itself may be missing. These situations require different responses. Sending the doctor on another generic course is unlikely to solve a missing opportunity to supervise, just as requesting a stronger reference cannot replace a capability that has not yet been demonstrated.

Ravi's comparison with the Specialist person specification reveals all four kinds of gap. His clinical role is substantial but its current scope is poorly described. The improvement project has useful organisational records needing an authorised summary. His teaching evidence shows

coordination but little observed feedback on his own teaching practice. A requirement concerning educational supervision cannot be met by relabelling teaching sessions. The gap analysis therefore produces a mixed plan: clarify scope, retrieve and prepare evidence, arrange observation and seek a suitable supervised development opportunity.

The first request should state the requirement and what is currently missing. Ravi might write that he is assessing readiness for a named role, that his teaching record demonstrates programme coordination, and that he needs an opportunity to develop and demonstrate a specified supervisory responsibility. He should then propose an appropriate activity, supervisor, time commitment and review point. The request becomes discussable because it identifies what the organisation would need to provide and how progress could be evaluated. It is more useful than asking for unspecified career support.

Make the organisational dependencies explicit. Development may require access to a clinic, an assessor, a suitable learner, study leave, data support or a change in workload. The doctor may control preparation and engagement while the employer controls access and time. Record each dependency beside the proposed action. If agreement is obtained, carry the relevant duties and resource implications into the job planning process. A development objective should not silently become an additional permanent commitment simply because the doctor is motivated to progress.

Use proportionate milestones. For an observed teaching objective, an initial discussion might agree the session and learning outcomes, followed by observation, feedback and a later session demonstrating response. For an improvement objective, milestones might cover agreement of a problem, approval of a measure, a small test and evaluation. Milestones should expose whether the opportunity actually occurred. Completing an application form for study leave is not equivalent to attending the activity, and attending the activity is not equivalent to demonstrating the intended capability.

If the requested opportunity is unavailable, ask what alternative would address the same requirement. An alternative must be educationally and evidentially credible, not merely easier to arrange. There may be a different service, an external collaboration or a longer timetable. Where no alternative exists, record the constraint honestly and reconsider readiness for the immediate application. This may be disappointing, but it is preferable to a portfolio built on ambiguous claims. Chapters 14 to 18 examine the different progression routes and the opportunities each may require.

Evidence of fair effort is still worth retaining when an objective is delayed. Keep the agreed plan, requests, responses and revised dates in the appropriate employment or development record. This supports a clear account at review and can identify a repeated access problem. It does not automatically prove entitlement to a particular post or outcome. If opportunities appear to be distributed unfairly, use the relevant local process and representation rather than turning the portfolio into a running accusation. Specific records support a better conversation than inferred motives.

Set a date to revisit the opportunity request. Without one, an apparently supportive response can leave both parties waiting for the other to act. Identify who will arrange the next discussion and what information should be available by then.

At the end of the gap review, Ravi has fewer claims ready for immediate use but a more credible application strategy. He can distinguish evidence already available, evidence awaiting preparation and capability still requiring development. That distinction allows him to decide whether to apply now, seek advice about the vacancy or prepare for a later opportunity. The portfolio has done its job by improving the decision, even before it produces another document.

## Annual maintenance

Portfolio maintenance works best as a modest routine connected to existing reviews. It should not depend on remembering an entire year during the week before appraisal. Nor should it require recording every conversation. Identify the activities likely to matter, capture a short index entry while their purpose remains clear and retrieve suitable evidence at an appropriate point. This approach reduces reconstruction and makes it easier to obtain confirmation from colleagues who still remember the work. The frequency suggested here is a practical routine, not a regulatory requirement.

At the start of a working year or appraisal period, review your scope, forthcoming decisions and previous development objectives. Note changes in role, clinical setting, working pattern or external responsibility. Identify projects and learning activities that may produce useful evidence, together with their approval and confidentiality arrangements. Where a future application is likely, refresh the relevant requirements rather than relying on a previous vacancy's person specification. Preserve the version used for planning so that a later change can be recognised rather than mistaken for personal inconsistency.

Every quarter, review what has actually happened. Add significant completed work, update ongoing items and close abandoned plans with a short explanation. Ask whether outcomes have become available since an earlier entry and whether a promised observation or confirmation remains outstanding. A short regular review can also reveal imbalance: plentiful course certificates but little evidence of applying learning, or extensive clinical activity with the educational role almost absent. The response should be better selection and appropriate development, not a race to fill every category numerically.

Before appraisal, use the index to select material addressing the whole scope of practice and the applicable supporting-information requirements. Keep the submission coherent enough for an appraiser to read and discuss. A large archive can support a concise submission; it need not be uploaded wholesale. Review the previous personal development plan and explain completed, changed and outstanding objectives. Check that statements about activity are supported and that a proposed new objective has the necessary opportunity, time or advice identified. Chapter 10 provides the fuller preparation sequence.

After appraisal, preserve the agreed outputs in the authorised system and update the index to show where they can be found. Record the new development objectives and their review points. Do not rewrite the underlying history to make the outcome look inevitable. If a factual correction is needed, use the relevant amendment process and retain a clear account of the change. Where a separate job plan or pay progression decision follows, record that outcome separately so that later readers do not mistake an appraisal discussion for an employment determination.

At the annual archive review, separate active evidence from historical material, remove unnecessary duplicates through the proper process and check access to important records. Review retention and sharing restrictions, especially for material carried forward from a former role. Confirm that the authorised backup or export arrangements work and that a future loss of an employer account would not remove every copy of documents you are entitled to retain. Do not test recovery by moving sensitive information into a new, unapproved location simply for convenience.

The maintenance checklist is therefore a sequence of questions: is scope current; are important activities indexed; are claims supported; are permissions and restrictions clear; are gaps linked to actions; are agreed outputs preserved; and can the relevant evidence be retrieved? Ravi uses these questions at each review rather than rebuilding his folders. Over time,

his portfolio becomes smaller in its active view and more useful in its explanations. The measure of success is readiness for the next professional conversation, not the number of files stored.

An occasional review with a trusted colleague can expose assumptions that self-review misses. Ask the colleague to identify what an example demonstrates before explaining what you intended it to show. A mismatch often reveals a missing contribution statement or an outcome asserted more broadly than the evidence supports.

## Portability through career change

Career change tests whether a portfolio is genuinely maintainable. An employer account may close, an appraisal platform may change, a verifier may retire and an organisational report may become difficult to retrieve. Planning before departure is therefore much easier than trying to reconstruct evidence afterwards. Begin by distinguishing material you are entitled to retain personally from records held for the organisation's purposes. Employment in a service, authorship of a document or previous access to a system does not automatically settle every question about future copying or use.

Prepare a departure evidence plan with the relevant administrative and information governance teams. Identify personal appointment and qualification records, agreed appraisal outputs, authorised summaries of activity and confirmations of roles or contributions that may legitimately be retained. For sensitive organisational material, seek an appropriate summary or a documented route for later access rather than forwarding whole folders to personal email. The purpose is continuity of professional evidence with a clear lawful basis, not acquisition of a private archive of the former service.

Obtain confirmations while colleagues can still check the facts. A role statement should give dates, responsibilities and the basis of the confirmer's knowledge. An improvement summary should identify your contribution and the status of outcomes at the point you left. If a project continues under another lead, record that boundary. Do not claim results achieved after your departure as if you personally delivered them. Equally, a later completion does not erase your earlier contribution; it can be described accurately when suitable evidence becomes available.

For a prospective Portfolio Pathway application, discuss evidence verification before key colleagues leave or access arrangements change. Use the GMC's current verification requirements and specialty guidance to identify what preparation is appropriate. A general farewell letter may be welcome but may not perform the required verification function. Keep

professional contact details through appropriate channels and avoid assuming that someone who once supervised you will indefinitely be available or able to verify later material. Early planning protects both the applicant and the colleague asked to confirm the record.[80]

Moving between nations requires a new operational map as well as preservation of evidence. The professional history remains yours to describe, but the appraisal system, employer processes and progression opportunities may change. Carry forward the relevant outputs and explain which role and period each covers. Do not make a previous platform's categories the governing structure for the new employer. Similarly, distinguish evidence that supports a continuing professional capability from proof of appointment to a particular local role. A former leadership title does not itself confer authority in the new service.

Reduction in hours or partial retirement can also change the portfolio's emphasis. Record duties relinquished, responsibilities retained and any new limits or support arrangements. An earlier broad scope should not remain the apparent current scope after substantial work has ended. Conversely, a smaller number of working sessions does not make ongoing educational, leadership or clinical responsibilities disappear. The evidence plan should follow the work that continues, including any separate professional role outside the main employment. Chapter 22 returns to these transitions and their practical handover requirements.

When an approved export is available, inspect it before the old account closes. Check that attachments, dates and agreed outputs are readable and that links do not simply return to a system you will no longer be able to enter. Record any missing element while the support team can still assist. This practical check distinguishes having downloaded a file from having preserved usable evidence. It also prevents a future application deadline from becoming the first test of an export made months earlier.

Ravi produces an application with fewer attachments than expected. Each item has a defined purpose, an account of his contribution and an appropriate source. He records development needs, permissions and a method for maintaining evidence. Appointment remains a separate competitive decision, but he can now describe his practice without relying on volume or memory. This is the portfolio's durable value: reliable evidence that travels through a career while respecting the people and organisations whose work it represents.

Chapter 13

# Feedback concerns and formal processes

## Feedback is not one category

Dr Imran Malik, a composite Specialist working in an English hospital, opened an email headed "formal concern" on a Friday afternoon. A family had complained after a delayed diagnosis. The clinical governance team was reviewing the incident, his clinical lead wanted a meeting, and the letter said that information might be shared with the GMC. His appraisal was due in six weeks. Imran read all of this as one verdict. He began drafting a long defence of his practice before he had established what any organisation was asking him to do.

The first discipline in this situation is classification. Informal feedback is information offered to improve or reinforce practice. A complaint is an expression of dissatisfaction handled through the applicable complaints procedure. A patient-safety incident response asks how care occurred and what can be learnt. A clinical-negligence claim tests civil liability and compensation. A coroner's investigation in England, Wales or Northern Ireland, or a procurator fiscal investigation in Scotland, has a different legal purpose. An employer may examine facts, competence, conduct, attendance or health under separate local procedures. The GMC considers whether information raises a question about fitness to practise and whether regulatory action is required. One event can enter several routes, but the routes do not merge into one.

Classification matters because the recipient, deadline, disclosure rules and purpose differ. A thoughtful response prepared for a learning meeting may be unsuitable as an unreviewed response to a legal claim. A clinical record is not the place to argue with a complaint. An appraisal reflection does not replace information requested by an investigator. Conversely, notification to the GMC does not prove that the employer's allegation is established or that the regulator will open an investigation. Treat each document according to what it says has begun, rather than according to the most frightening possibility it mentions.

Create a process identifier before writing a substantive response. Record the sender, organisation, date received, precise title, reference number, stated purpose, issue described, response required, deadline and named

contact. Add a column for advice: defence organisation, trade union or professional association, employer human resources, legal representative, responsible officer, occupational health or another appropriate source. Do not circulate the correspondence widely to seek reassurance. Confidential material and tactical advice should remain within authorised channels.

Some communications do not clearly identify their process. A request to "come for a chat" may be an ordinary management conversation, early fact finding or part of a formal procedure. Ask calmly: What is the purpose and status of the meeting? What issues will be considered? Who will attend? May I bring a representative or companion? Is any written response required beforehand? Which policy applies? These are not obstructive questions. They allow everybody to prepare for the same meeting.

Imran's initial map contains four live strands: the family's complaint, the patient-safety review, an employer fact-finding exercise and a possible GMC referral. His appraisal is a fifth professional process, but not an investigation. The map immediately changes his task. He needs to preserve records and obtain advice across the live processes; he does not need to produce one document that purports to settle all five.

Add a "do not confuse with" line to every strand. The complaint is not the same as a clinical-negligence claim. The incident review is not the employer's determination of misconduct. The responsible officer's awareness is not a GMC sanction. The regulator's assessment is not a criminal trial. This small line disciplines language in later correspondence. If a colleague says that "the investigation found" something, the record should identify which investigation, the question it was authorised to answer and the wording of its actual conclusion.

Not every criticism should be escalated into machinery. A colleague who says that a handover was unclear may be offering useful feedback rather than initiating a complaint. Ask enough to understand the example, thank them where appropriate, examine the work and agree follow-up. Formality becomes necessary when the concern, policy, fairness or risk requires it. Over-formalising every comment discourages learning; under-classifying a serious allegation deprives everybody of safeguards. The process identifier helps locate that boundary.

## The first twenty four hours

The first day is for control, not rhetorical perfection. Read every page, including attachments and links to policies. Confirm what is alleged and what remains unclear. Note deadlines in a secure calendar and distinguish a deadline to acknowledge receipt from a deadline for a substantive response.

If essential information is missing or advice cannot reasonably be obtained in time, request clarification or an extension promptly. Do not assume that asking pauses the deadline; obtain the answer in writing.

Preserve relevant material. This may include the clinical record, rota, job plan, applicable protocol, emails, messages held on authorised systems, incident report, meeting records and evidence of actions taken after the event. Preserve does not mean secretly downloading an entire patient record to a personal device. Use organisational and legal routes to protect access to material while respecting confidentiality. Do not alter, backdate or tidy an original record. If a legitimate later clinical addendum is necessary, make it transparently under the approved record system, with its actual date and reason. Good medical practice requires records to be clear, accurate, contemporaneous where possible and not improperly amended.[81]

Write a private factual aide-memoire while events are fresh, using an authorised and confidential arrangement agreed with your adviser or employer. Separate what you personally saw, heard, decided and did from information learnt later. State the source of later information. Avoid adjectives about motives or competence. "At 14.20 I telephoned the duty radiologist; the call log records a four-minute call" is more useful than "radiology refused to help" when the content of the conversation remains disputed. Do not create a document and then assume it is legally privileged merely because it is labelled confidential.

Notify the right adviser. A medical defence organisation can advise on complaints, coronial or procurator fiscal processes, claims and GMC matters within the terms of membership. A trade union or professional association may advise and represent in employment procedures. The two functions can overlap but are not interchangeable. Check membership and occurrence dates rather than assuming cover. If the issue involves police, court, regulator, suspension, exclusion, restriction of duties, dismissal risk or a demand for a detailed written account, seek advice before providing more than any necessary immediate acknowledgement.[87]

Protect patients while advice is being arranged. If the correspondence identifies an unresolved clinical task, current safety risk, missing result or record error, ensure it reaches the authorised team capable of acting. Do not wait for a complaints response. Equally, do not contact the patient or family outside the agreed route merely to persuade them that the complaint is mistaken. A clinically necessary communication, an explanation under candour arrangements and a complaint response may require coordination; establish who owns each.

Avoid three predictable reactions. First, do not send an immediate point-by-point rebuttal copied to a large audience. Second, do not delete informal messages, draft notes or diary entries because they now feel embarrassing. Third, do not approach colleagues to align recollections. You may properly alert a relevant manager that material must be retained, but witnesses should provide their own accounts. Any suggestion that evidence was influenced can become more serious than an imperfect initial decision.

Attend to health and function. A formal letter can produce sleeplessness, impaired concentration and catastrophic thinking. Decide whether you are fit for the next clinical session. Speak confidentially to a GP, occupational health service, practitioner-health service where eligible, or another appropriate clinician if needed. This is not an admission about the allegation. It is ordinary professional responsibility. The GMC's decision principles distinguish a health condition from its possible effect on safe practice; health alone does not undermine public confidence.[82]

Imran's first-day record is deliberately short: correspondence received at 15.42; acknowledgement due Monday; substantive employer account requested in ten working days; complaint response owned by the complaints team; incident review lead named; no direct GMC correspondence yet. He secures the emails within the employer system, writes a chronology of his own actions, contacts his defence organisation and employment representative, and confirms that the current patient-safety issue has been addressed. He does not spend the weekend writing an unadvised confession or a manifesto about systemic failure.

The first-response checklist is therefore: identify every process; record every deadline; preserve without altering; address immediate safety; obtain the correct advice; acknowledge proportionately; protect confidentiality; assess your own fitness to work; and record next actions and owners. It is a stabilising device, not a substitute for the governing procedure.

## Complaints and patient safety incidents

A good complaint response recognises the complainant's experience while remaining accurate about what is known. Acknowledging distress is not the same as accepting every allegation. An apology is not necessarily an admission of legal liability, and professional candour should not be avoided simply because a claim is possible. The joint professional duty of candour guidance expects doctors to be open and honest when something has gone wrong, to apologise, explain what is known and what will be done, and report the incident through the appropriate system.[83] The exact statutory or

organisational duty of candour differs among the UK nations, so the local route and responsible person must also be identified.

Start with the clinical sequence and the questions raised. What was the patient's condition? What information was available to each decision-maker at the time? What did the applicable pathway require? What decisions were made, by whom and why? What happened next? What effect did the event have? What remains uncertain? This sequence allows a response to distinguish a poor outcome from a departure in care, and an individual action from a pathway involving several teams.

Do not write as if candour requires certainty that does not exist. An early conversation may need to explain that an incident is being examined and that further information will follow. Say what is known, what is not yet known and how the person will be updated. If later evidence changes the account, correct it openly. A polished but premature causal explanation can harm trust and distort the investigation.

Patient-safety work should seek learning proportionate to the event, including the conditions in which people worked. In England, the Patient Safety Incident Response Framework and associated standards place emphasis on system-based learning, engagement and proportionate responses rather than treating every event as requiring the same investigation product.[84] Scotland, Wales and Northern Ireland have their own arrangements. The transferable method is to examine how care was organised while still assessing individual decisions fairly.

Imran's clinical decision occurred during a handover between two services. His initial impulse is to state that the other service failed. The review shows a more complicated sequence: the referral information was incomplete; Imran made a reasonable initial plan; a later result was filed in a location neither team routinely monitored; and the ownership of follow-up was ambiguous. His own record did not explicitly allocate the pending result. The systems context matters, but it does not remove the need to examine his contribution. He can acknowledge that a clearer named handover would have reduced risk without claiming sole responsibility for the entire pathway.

Separate the products. The patient or family needs a humane, comprehensible response. The patient-safety team may need detailed evidence about the pathway. The clinical record must support continuing care. The governance forum needs actions, owners and measures. Imran's appraisal later needs a confidential, proportionate reflection on learning. Copying the same technical account into all five settings would serve none of them well.

Learning actions should correspond to the failure mechanism. "Attend a communication course" is weak where the central problem was an unallocated result queue. A stronger response might clarify ownership at transfer, introduce a visible task field, test whether results are acknowledged and review exceptions after an agreed period. If Imran also identifies an individual communication gap, he can seek observation and feedback on that specific behaviour. Remediation is credible when action, relevance and verification align.

Keep the complaint outcome distinct from the safety conclusion. A complaint may be upheld, partly upheld or not upheld under the applicable procedure, while a safety review still identifies improvement. A complainant may remain dissatisfied even after a sound process. Neither response, by itself, determines employment capability, misconduct, civil liability or fitness to practise. Record what each process actually decided and resist converting a conclusion from one jurisdiction into a universal verdict.

Before a response is approved, test it from the reader's position. Does it answer each question in ordinary language? Does it distinguish established fact, professional interpretation and pending review? Does it explain what has changed, who owns that change and when the family will hear again? Does it avoid blaming an absent colleague or hiding behind unexplained policy wording? A technically accurate chronology can still be experienced as evasive if it never addresses the person's central concern.

Close the learning loop after the response. An action such as "remind staff" needs an audience, method, responsible owner and test. A redesigned handover field needs confirmation that it is available, used and effective. Share relevant learning through authorised governance routes without replaying identifiable details. If the review identifies a wider risk beyond Imran's service, ensure that a forum with authority to act receives it. Complaint handling becomes safer when explanation and system improvement remain connected.

## Employer fact finding capability and discipline

Employer action begins with the applicable documents. Retrieve the local policy named in the letter, the relevant national framework where incorporated, your contract and job description, and any correspondence defining the scope. Policies vary among employers and nations. Titles such as preliminary assessment, case investigation, maintaining high professional standards, capability, conduct, grievance, attendance or restriction of practice may carry different meanings. The handbook cannot tell an

individual doctor which legal route an employer should use; it can help expose whether the employer has identified one.

Fact finding should establish information before a conclusion is reached. The invitation should allow the doctor to understand the issue sufficiently to participate. Ask who commissioned the work, who is gathering facts, what period and allegations are in scope, what documents will be considered and what output is expected. Ask about accompaniment or representation, confidentiality, note-taking and opportunity to correct factual inaccuracies. These questions help prevent an exploratory meeting from later being remembered as a formal admission.

Capability and conduct are not synonyms. Capability generally concerns whether required work can be performed to the necessary standard, which may involve competence, systems, health, resources, training or the match between role and person. Conduct concerns behaviour and compliance with expected standards. An incident can raise both, but a fair process should say what is being considered. Health and disability may require occupational-health input and reasonable-adjustment consideration; they should not be used as shorthand explanations without evidence.

Restriction of duties, relocation, supervision, exclusion or suspension can be described as neutral or precautionary, but each may have major consequences. Obtain prompt representation and the written basis, scope, review arrangements and practical conditions. Clarify pay, access to systems, contact with colleagues, appraisal, CPD and communication with external organisations. Do not breach a direction while contesting it. If a restriction itself creates a patient-safety problem or prevents required remediation, raise that through the advised route.

The employer should distinguish an immediate risk-control decision from the final merits. Temporary supervision while facts are gathered does not establish deficient performance. Conversely, the absence of restriction does not prove that no concern exists. Imran's manager reallocates one aspect of his practice pending review. Imran records the limits and review date, follows the arrangement, and asks for access to supervised activity relevant to the issue. He does not describe the temporary change as either exoneration or punishment before the process has decided.

Prepare for interview by mapping allegation to evidence. For each issue, write: what is alleged; what you accept as fact; what you dispute; what you do not know; the contemporaneous source; relevant context; and any current safety action. Take the original documents or authorised copies, not a newly curated narrative alone. Listen to the precise question. If you cannot recall,

say so. If a document would help, ask to see it. Guessing in order to appear cooperative can create contradictions that later look deliberate.

Representation changes the quality of preparation, not merely the tone of the meeting. A representative can help identify policy, scope, disclosure, timescales, fairness and the boundary between employment and regulatory issues. Share material early enough for meaningful advice. A representative cannot make inaccurate evidence reliable, nor should they coach a doctor to avoid obvious professional learning. The objective is a fair, evidenced response and a workable outcome.

Possible employer outcomes are wider than guilty or cleared. A matter may close with no action, informal management advice, agreed development, occupational-health support, supervised practice, a capability plan, a disciplinary stage, contractual action or referral elsewhere, depending on facts and procedure. Ask for the findings, evidential basis, decision-maker, actions, timescales, review method and any appeal or review route. Correct material factual errors promptly, while distinguishing disagreement with interpretation from an inaccurate record.

System factors should be presented precisely. Staffing, workload, missing information, supervision and unclear authority may materially explain how an event occurred. Evidence them through rotas, escalation records, policies and contemporaneous communications. Do not use "the system" as an unidentified alternative defendant. State what condition existed, how it affected the decision and what responsibility remained with you. This is both more candid and more persuasive than either accepting everything or blaming everyone else.

Appraisal should continue where appropriate, but it must not be used to run a parallel disciplinary hearing. Tell the appraiser about relevant complaints, restrictions or investigations as required, with advice about sensitive content. The appraiser can support reflection and development; they are not the fact finder or employment decision-maker. If necessary information or timing affects appraisal or revalidation, contact the appraisal team or responsible officer rather than silently omitting the matter. Chapters 10 and 11 explain those distinct decisions.

Check procedural fairness against the actual policy rather than a vague expectation of natural justice. Has the concern been particularised? Has relevant material been disclosed subject to lawful limits? Is the investigator suitably independent for the role assigned? Has the doctor had a reasonable opportunity to respond? Has evidence that does not support the allegation also been considered? Is the decision being made by the authorised person?

A representative can identify which questions are legal or contractual and which are requests for better administration.

Meetings need an accurate record. Clarify whether a formal note or recording will be made and follow the governing policy. Do not make a covert recording without specific advice. Read the note promptly, correct factual errors with reasons and distinguish a correction from a later change of view. If disagreement remains, ask that it be recorded rather than refusing to engage with the entire note. Preserve the version circulated and your dated response.

If new allegations arise, ask for them to be stated and for adequate preparation time. A fact-finding interview should not become an improvised hearing on unrelated conduct. This does not mean refusing every unexpected question; it means identifying when the scope has materially changed. Similarly, if evidence points away from personal capability and towards a service defect, the organisation should not force the material into its starting theory. A fair process can change direction as facts emerge.

## How the GMC assesses information

A referral is information, not a finding. The GMC first decides whether the information concerns a registered doctor, whether there is a legal basis for assessing fitness to practise, whether the matter would be sufficiently serious if proved, and whether there is a reason not to open an investigation. Current guidance frames the assessment around potential current and ongoing risk to public protection, taking account of seriousness, relevant context and the doctor's response, including insight, remediation and, where relevant, maintenance of knowledge and skills.[85] This is a regulatory test, not a general measure of whether care could have been better.

Public protection has three connected parts: patient safety and wellbeing, public confidence, and proper professional standards and conduct. A resolved clinical error may present little current patient-safety risk after effective action, while exceptionally serious conduct can still engage public confidence or professional standards. Equally, an unfortunate outcome is not automatically a fitness-to-practise concern. The regulator asks what the information, if evidenced, says about these statutory purposes and what action, if any, is now required.[82]

At this early stage, the GMC may close the matter, close it and notify the responsible officer, make no substantive decision because information is unavailable, await a relevant third-party process, or open an investigation. Limited further information or provisional enquiries may be used to clarify seriousness without automatically becoming a full investigation. The March

2026 guidance also explains that notifying a responsible officer after closure may support appraisal learning, identify a possible wider pattern or alert them to a local investigation.[85] A closed GMC matter can therefore still require thoughtful local follow-through.

Context is not an excuse added after responsibility has been denied. It is evidence about the circumstances, choices and present risk. Relevant context might include workload, supervision, team behaviour, deficient systems, discrimination, bullying, missing information or an emergency. Establish it with contemporaneous records and explain the connection to the alleged act. Also state what you could reasonably have done differently within those conditions. A credible account can recognise constrained choice without claiming that professional responsibility disappeared.

Insight is more than repeating that an event was regrettable. It involves understanding the concern, its effects, one's part in it, the standards engaged and the risk of repetition. Remediation is the action taken to address an identified problem. Its weight depends on relevance, completion, evidence and whether improvement is sustained. A generic course chosen because its title resembles the allegation may demonstrate little. Supervised cases, targeted learning, changed process, audit and independent feedback can be stronger when they address the actual mechanism.

None of these factors guarantees closure. Some concerns may remain serious because of their nature, pattern or implications for public confidence and standards, even where patient-safety risk has been addressed. Current GMC principles stress proportionality—what is required, and no more than necessary, to meet the public-protection duty—alongside transparency and fairness.[82] A doctor should therefore show genuine learning without trying to reverse-engineer a supposedly safe formula.

The GMC also recognises that culture, language, disability and neurodiversity can affect communication and how behaviour is perceived. Its March 2026 decision principles require decision-makers to consider relevant known information and guard against bias while applying the same professional standards.[82] If such context is relevant, explain it specifically and consider reasonable adjustments for participation. Do not assume it will be obvious from an email, and do not present identity as a reason standards should not apply.

Imran receives confirmation that the GMC is assessing information supplied by the employer. With advice, he provides the requested factual material, the current local status and evidence of the immediate safety response. He does not send his entire appraisal portfolio or speculate about the complainant's motives. His chronology distinguishes the original

decision, the later result, the transfer-of-care ambiguity and the changes already tested. The GMC's decision remains for the regulator; his task is to provide accurate, relevant information and engage appropriately.

Health information requires particular care. A condition is relevant to fitness to practise when its impact may affect safe and effective practice, not simply because the diagnosis exists. A doctor should seek care, follow appropriate advice and communicate necessary restrictions through proper channels. Hiding a material effect on practice can increase risk; disclosing an entire medical history to everyone involved can be unnecessary and harmful. Obtain advice about the appropriate evidence and consent arrangements.

Do not treat the complainant's withdrawal as automatic closure. The regulator may still assess whether public protection requires investigation. Nor should a doctor assume that an old event can never be considered; the GMC's rules and guidance include a five-year provision with public-interest qualifications.[85] These are reasons to seek case-specific advice, not to calculate an outcome from a handbook.

The safest working model has four questions. What information is actually before the GMC? Which legal or professional concern may it engage? What evidence bears on seriousness, context and present risk? What accurate response and current action can be demonstrated? This model keeps attention on the decision being made rather than on imagined headlines or anecdotes about unrelated cases.

Seriousness is assessed on evidence and the possible implications, not on how many times an allegation is repeated in correspondence. Relevant features can include actual or potential harm, repetition, persistence, premeditation, abuse of power and the extent of departure from professional standards. The GMC's current principles also require scrutiny of the quality and objectivity of information, not acceptance of a source at face value.[82] A doctor should therefore address both the alleged conduct and the evidential reliability without dismissing the concern solely because it came from a difficult relationship.

The response should also show the present position. If practice has changed, say when, why, how it is observed and whether the change is sustained. If no change was necessary because a crucial factual premise is wrong, provide the evidence and still ask whether the event exposes another learning point. If a risk depends on a particular environment, explain whether that environment continues and what protection now applies. Present risk cannot be understood from the historic event alone.

## Investigation interim action and possible outcomes

If a full investigation opens, the doctor should obtain the current GMC explanation of stages and the correspondence specific to the case. The process may involve documentary evidence, statements, expert or performance material, health assessment in relevant cases, and an opportunity to respond. Case examiners or other authorised decision-makers may decide an outcome, and some matters may be referred for a Medical Practitioners Tribunal. The route depends on the nature and evidence of the concern; a schematic overview cannot predict the sequence in an individual case.

Interim action is separate from the final decision. An Interim Orders Tribunal considers whether registration should be restricted while concerns are being considered. Under the MPTS guidance effective from November 2025, an interim order may impose conditions or suspend registration, and the tribunal assesses risk, necessity and proportionality. An interim restriction is not a final finding that the allegation is proved.[86] Because such a hearing can immediately affect work, obtain specialist representation and comply with the order while using any available review or challenge route advised for the case.

An employer and the GMC may impose different practical controls. Employer supervision limits what work the organisation permits. GMC conditions attach to registration and must be observed across practice within their terms. A doctor working in more than one role must ensure every relevant organisation knows what it is lawfully required to know. Do not assume that telling one manager updates all employers, locum agencies, private work or voluntary clinical roles.

Possible regulatory outcomes include closure, warning, agreed undertakings in suitable circumstances, or referral to a tribunal; a tribunal may find fitness to practise not impaired or impose a sanction within its powers. Exact routes, tests and publication rules change and must be taken from current GMC and MPTS material. The existence of several outcomes matters: investigation does not predict erasure, and early closure does not mean the underlying event has no learning or employment consequence.

Respond to requests within the stated scope. Maintain an index of material sent: document title, date, source, redaction status, request answered and submission date. Keep the covering correspondence and confirmation of receipt. If a requested document is held by an employer, identify that rather than implying you possess it. If disclosure would raise confidentiality, data-protection or court issues, obtain advice; do not solve

the problem by silently omitting the item or sending unredacted material through an insecure route.

Regularly reconcile the processes. A local report may finish while the GMC investigation continues. A civil claim may begin after the complaint closes. The responsible officer may need enough information to manage revalidation without adjudicating the allegation. Keep a one-page process table showing status, next action, owner and date. It reduces the risk that a deadline in a quiet process is missed because attention is consumed by a more visible one.

Communication with colleagues also needs control. There may be a legitimate need to arrange work, obtain evidence or seek confidential support. There is rarely a need to give the whole department a running commentary. Agree factual wording with the employer where a change in duties affects the team. A short statement that arrangements are under review and named clinical cover applies may protect patients and privacy better than either silence that creates operational confusion or uncontrolled detail that fuels rumour.

If media or social-media contact occurs, do not debate the case publicly. Confidentiality continues even when another person publishes allegations. Preserve the material, inform the relevant organisation and adviser, and use an agreed communication route. A defensive post written in distress can disclose patient information, prejudice a process or create a separate professional concern. Public silence is not acceptance of an allegation.

The practical aim during investigation is reliable engagement: maintain safe practice within any limits, provide requested information accurately, seek extensions before rather than after deadlines, update advisers, care for health and continue relevant development. Avoid performing remorse for an allegation you genuinely dispute. It is possible to recognise a patient's experience, identify learning and cooperate while setting out a reasoned disagreement with facts. Accuracy and insight can coexist.

At each stage, read the decision letter for what happens next. Identify whether reasons are final or provisional, whether representations are invited, which material will be disclosed, and any route or deadline for review or appeal. Do not rely on an earlier general webpage where the letter gives case-specific directions. Ask the adviser to explain both the immediate task and the consequence of doing nothing.

If undertakings or conditions are proposed, examine whether each is clear, workable, measurable and compatible with employment. Who can supervise? Which reports are required? What happens during leave or a job change? A condition that depends on a role the employer will not provide

may prevent practice even if it sounds achievable. These questions require case-specific representation; the doctor should not negotiate complex restrictions alone.

Where a tribunal referral occurs, the MPTS is independent in its adjudicative role. Preparation will involve the applicable rules, disclosure, witness evidence and expert advice rather than simply expanding the doctor's first written account. Keep the chronology and evidence index stable, but allow formal representatives to shape the case required by the tribunal. The purpose of early organisation is to preserve reliable material, not to predetermine litigation strategy.

Continue ordinary governance obligations during a long process. Renew required training, keep within scope, report new significant events and maintain appraisal communication unless advised otherwise. Do not treat the existence of an investigation as permission to stop professional development, and do not overload the portfolio with every procedural email. The professional record and the case file need connected but separate management.

## Evidence chronology and response

A chronology is an analytical tool, not a diary enlarged until nothing is readable. Begin with the issue period and add dated events that bear on the allegation, care, decisions, systems context and subsequent action. For each entry record the time or date, event, source, people or roles involved, what was known then, action, and any uncertainty. Add later information at the later date. This prevents hindsight from being inserted into the original decision.

Use three evidence labels: contemporaneous, retrospective and contextual. Contemporaneous evidence was created at or near the event, such as a clinical entry, rota or email. Retrospective evidence is a later account or confirmation and should be identified as such. Contextual evidence explains the environment, such as staffing data, job-plan responsibilities or the pathway then in force. None is automatically decisive. A contemporaneous record can be incomplete; a retrospective account can be accurate; a policy can differ from actual practice. The strength lies in relevance, authenticity and fair interpretation.

Build an allegation matrix beside the chronology. Column one reproduces each allegation neutrally. Column two states admitted fact, disputed fact or insufficient information. Column three lists evidence. Column four identifies professional or procedural context. Column five records current action. Column six contains points requiring advice. This

prevents a response to a broad allegation from becoming either a blanket denial or a general autobiography.

Draft in layers. First, state the relevant role and scope. Second, give the chronology. Third, answer each issue. Fourth, explain context and contribution without evasion. Fifth, describe patient impact and communication where known. Sixth, set out completed and planned action with verification. Finally, identify any factual records or conclusions that remain disputed. The adviser can then assess legal and procedural implications before submission.

Do not overclaim corroboration. A colleague's email that confirms the rota does not prove the content of a private conversation. A policy in force does not establish that staff had access to it or that its required resource existed. An audit showing improvement after an intervention does not prove one individual caused the change. Use evidence for what it can sustain. Narrow statements often carry more credibility than ambitious claims attached to weak support.

Imran's matrix reveals that he accepts the handover did not name the clinician responsible for the pending result. He disputes an allegation that he ignored an already available result because the system audit records that it became visible after his shift. He acknowledges that the family experienced delay and uncertainty. He supplies the approved pathway and rota to explain divided responsibility, while accepting that he could have recorded ownership more explicitly. His remediation includes a tested handover field and audit of acknowledgement; it is not presented as proof that the original care was faultless.

The advice record should document the adviser, capacity, date, question, material provided and agreed next action. Do not reproduce confidential legal advice unnecessarily. The record's purpose is to prevent crossed instructions and forgotten deadlines. Where employment and regulatory advisers cover different issues, ask who will coordinate or how consistent factual accounts will be maintained. Factual consistency does not require identical submissions because each process asks different questions.

Before sending, perform five tests. Does every assertion have a source or is it clearly identified as recollection? Have patient and third-party details been handled lawfully? Does the response answer the actual request? Are learning and context described without unsupported admission or blame? Has the appropriate adviser reviewed it? Then keep the submitted version. An editable draft without a dated final copy is a poor record of what the decision-maker received.

## Reflection remediation and professional support

Reflection is professional work, not a ritual declaration of fault. It should show what changed in understanding and practice. The joint reflective-practice guidance advises anonymisation and explains that reflective notes are not intended to reproduce the full factual detail of an incident; necessary factual records belong in the relevant clinical or governance system.[65] This separation protects confidentiality and improves reflection. The doctor can examine judgement, communication and learning without constructing a parallel patient record in the portfolio.

Use a five-part reflective sequence: what question did the event raise; what did I understand at the time; what do I understand now; what have I changed; and how will I know whether the change works? Add a sixth question where relevant: what organisational condition also requires action, and who owns it? This makes personal accountability compatible with systems thinking.

Remediation should be designed from the concern. A knowledge gap may require study, assessment and observed application. A technical skill may require supervised practice and competence evidence. Communication difficulty may require targeted feedback across relevant encounters. A system weakness may require a process change with an owner and measure. Health-related risk may require treatment, occupational-health advice and workable restrictions. Dishonesty or boundary concerns require specialist advice and cannot be remediated through a generic course alone.

Verification matters. "I reflected" describes an activity. A supervisor's direct observation, audit of later practice, feedback, successful assessment or sustained outcome may show whether change occurred. Choose verification proportionate to the issue. Do not recruit friendly colleagues to write broad testimonials unrelated to the concern. Character evidence and performance evidence answer different questions and should be labelled accordingly.

Avoid manufactured remorse. If facts are contested, distinguish them from accepted learning. A sentence such as "I do not accept that the result was visible during my shift; I do accept that our handover did not allocate responsibility clearly, and I have changed that practice" is more useful than an apology for facts the evidence does not support. Advice remains important because wording can affect parallel proceedings.

Professional support should be structured. Identify one confidential personal supporter, one appropriate clinical or educational supporter and the formal advisers. Do not ask one person to perform every role. A close friend can listen but may not understand a procedural deadline. A supervisor can

support safe practice but should not be assumed to provide legally confidential advice. A defence adviser can guide the case but cannot replace healthcare when the doctor is unwell.

Write a remediation specification before selecting an activity. It should name the concern being addressed, the capability or behaviour expected, the learning method, opportunity for application, independent observation, success measure and review date. Discuss it with the appropriate supervisor or adviser. This protects against collecting impressive but irrelevant courses and allows the doctor to demonstrate why the chosen action is proportionate.

For example, if the accepted gap concerns allocation of responsibility at transitions, Imran's specification includes observed handovers, explicit allocation of pending tasks, review of a sample of later transfers and feedback from the receiving team. It does not claim that one online communication module proves resolution. If the sample reveals continued difficulty, the plan changes. Remediation is a testable process, not a certificate-shaped conclusion.

Reflection may evolve. An early note can identify uncertainty and immediate questions. Later reflection can incorporate findings, patient perspective, professional advice and the outcome of tested change. Date each stage. Do not rewrite the early note so that it appears the final explanation was obvious from the first day. Development is more believable when the record shows how understanding changed.

Agree what the appraiser needs to know. Relevant complaints, significant events and restrictions cannot simply be excluded because they are uncomfortable. Yet the appraisal portfolio should not become a repository for privileged correspondence or identifiable investigation papers. Provide a proportionate account of status, reflection and development after advice, and make clear what remains unresolved. The appraiser should not be invited to decide contested facts.

## Recovery and return to ordinary practice

Resolution is rarely a single moment. A letter may close one process while supervision, learning, team relationships or revalidation questions continue. Make a closure schedule. For each strand record the decision, actions still required, review date, disclosure or publication position, records to retain under advice and the person who confirms completion. Do not infer that silence from another organisation means its process has closed.

Imran's employer concludes that the event reflected a shared pathway failure and an individual handover omission, with no disciplinary finding. The GMC closes its assessment after reviewing the available information

and notifies the responsible officer so that learning can be considered. Imran completes the agreed audit, discusses the matter at appraisal without asking the appraiser to reopen it, and retains the decision letters and approved evidence in the appropriate places. The complaint outcome and family communication are completed through the complaints team.

Returning to ordinary practice may need a written plan covering duties, supervision, access, learning and review. If restrictions have ended, ask for records and operational messages to be updated. Colleagues should not continue to follow an obsolete limitation. If confidence has been affected, graduated observation or peer review may be helpful even where it is not mandated. The purpose is safe, supported practice, not indefinite informal punishment.

Reputation cannot be repaired by disclosing confidential details to win every colleague's agreement. Use accurate organisational communication, dependable work and time. Challenge materially false employment records through the proper process, but accept that not every rumour can be corrected. A doctor who spends every meeting relitigating a closed allegation may unintentionally allow it to define the next year of practice.

Review health after the acute process. Sleep, concentration, relationships and willingness to seek help may remain affected after correspondence stops. Continue clinical support where needed. Consider whether workload, isolation, discrimination or moral distress require a separate workplace response. Recovery is not proved by returning immediately to every former commitment.

The process identifier can now become an archive index rather than a live alarm. Retain what is required or advised, dispose of unnecessary duplicate personal copies securely, and keep a concise account of outcome and completed learning. Do not erase the event from professional memory; do not preserve it in every folder. The aim is retrievable evidence without a permanent state of investigation.

Three questions mark a sound exit. Can you explain what each process decided without merging them? Can you demonstrate the action that remains relevant to present practice? Can you identify when future disclosure is required and obtain advice if unsure? If so, the experience has been converted into professional learning and reliable records rather than either denial or lifelong self-accusation.

Use a ninety-day return review even when the process closes without action. Check that duties and access match the written outcome; agreed learning is underway; appraisal and responsible-officer records are accurate; health support remains sufficient; and no temporary restriction has survived

by administrative drift. Then review at six months whether the relevant change has been sustained. A closed file is not the same as a completed recovery plan.

If the finding materially affects future applications, declarations or references, obtain advice on the exact question asked and answer it truthfully. Do not conceal a required disclosure, but do not volunteer confidential narrative unrelated to the question. Retain the source decision so that future answers use its actual language rather than a memory shaped by anxiety.

No handbook can decide how a doctor should answer a particular allegation, whether a procedural step is lawful, or what should be disclosed in litigation, an inquest, a fatal-accident inquiry, employment proceedings or regulatory correspondence. Those are points for timely individual advice. The contribution of a general framework is different: classify the process, secure the evidence, protect current patients, respond to the right question, show genuine learning and maintain the distinction between an allegation, a finding and a professional future.

Chapter 14

# Planning progression without a training number

## Choose the destination before collecting evidence

Dr Sara Khan, a composite Specialty Doctor in Scotland, had attended an impressive range of courses. Her portfolio contained leadership certificates, educational webinars, simulation training and several years of clinical continuing professional development. When she said that she wanted to progress, colleagues offered contradictory advice: apply for formal training, seek regrading, begin a Portfolio Pathway application, ask for a leadership title, or "carry on and wait". None began with the decision Sara actually wanted to make.

Progression is not one ladder. A doctor may want deeper expertise within a stable Specialty Doctor role, appointment or progression to the Specialist employment grade, entry on the GMC Specialist Register, an approved training programme leading to a CCT, a formal education or leadership role, an academic or improvement portfolio, a different working pattern, or some combination. These destinations overlap but have different decision-makers and evidence. A course cannot choose among them.

Write the destination as a decision that another person or body could recognise. "Become more senior" is too broad. "Be ready within eighteen months to apply competitively for a Specialist post requiring independent management of the defined clinical pathway and leadership of improvement" is testable. So is "develop an educational-supervision role for SAS and locally employed doctors, with agreed time and evidence of effective supervision". The first points to a vacancy and person specification; the second to local appointment requirements and education-provider standards.

Keep the Specialist grade distinct from specialist registration. The former is an employment grade under the applicable arrangements. The latter is a regulatory status determined by the GMC through an eligible route. A doctor may pursue either, both or neither. The GMC Portfolio Pathway requires evidence against the current curriculum and specialty specific guidance, including specialty-specific recency and referee requirements; it is not an

employment promotion scheme.[88] Chapters 15 to 18 examine the four principal routes separately.

Use a destination selector with six fields: desired work; desired authority or recognition; decision-maker; governing source; evidence standard; and acceptable alternatives. Ask what you want your working week to contain, not merely what title you want printed below your name. If the principal goal is more complex clinical practice with protected development time, a redesigned Specialty Doctor job plan may address it. If the goal is eligibility for consultant appointments requiring specialist registration, employment regrading alone cannot do that.

Sara chooses a primary destination: Scottish progression or regrading to the Specialist grade, subject to the current national policy and employer process. She retains two connected aims—improvement leadership and educational supervision—because they build capability she values whether or not the employment application succeeds. She does not begin a Portfolio Pathway application merely because colleagues treat it as the default badge of seniority.

The choice is provisional, not a lifelong commitment. Record why the destination matters, the assumptions on which it depends and the date for reconsideration. A service may not create the expected opportunity; a curriculum may change; health or caring responsibilities may alter timing. A robust plan can change without becoming a failed plan.

Apply four filters before adopting a destination. **Work** asks whether you want the daily responsibilities, not only the status. **Eligibility** asks what the current route actually requires. **Opportunity** asks whether the necessary experience can be obtained without unsafe overload. **Consequence** asks what the change would mean for location, on-call work, income, pension, family life and future options. A destination that survives all four filters deserves sustained effort; one chosen mainly to answer other people's expectations needs reconsideration.

Do not confuse a means with an end. Specialist registration may be necessary for a particular future appointment but unnecessary for the work the doctor wants now. A leadership fellowship may create useful experience but is not itself an organisational appointment. Regrading can recognise appropriate Specialist-level work where a national mechanism applies, but it does not automatically redesign a poor job plan. Write the intended end before selecting the route.

## Define current scope and level

Years in post describe duration, not automatically capability or level. Begin with current work. Use the job description and job plan, then compare them with actual practice: patient groups, complexity, decisions, procedural work, escalation, out-of-hours responsibilities, teaching, supervision, governance, service leadership and cross-organisational activity. Chapter 7's four-week diary and Chapter 12's evidence index provide the raw material.

Separate independent work from unsupported work. A doctor may make autonomous decisions within a defined scope with appropriate access to consultation. That can demonstrate senior capability. Being left alone because the rota is thin does not by itself establish that the work was appropriately designed or that every relevant capability is present. Describe the decisions, boundaries, support and outcomes rather than equating absence of supervision with expertise.

Use three evidence views. The first is self-description: what you believe you do and at what level. The second is documented practice: job-plan entries, activity summaries, governance records, assessments and outputs. The third is informed external view: feedback or observation from colleagues who understand the work and destination. Differences among the three are useful. If Sara describes service leadership but the record shows only attendance at meetings, she has found either an evidence gap or a role-design gap.

Peer review should be specific. Ask a colleague to examine a representative element of practice against the intended standard, not to provide a generic statement that you are excellent. For clinical scope this may involve case-based discussion, direct observation, review of outcomes or discussion of decision boundaries. For leadership it may involve examination of a service problem, the doctor's responsibility, choices, stakeholder work and evaluation. Select methods suitable to the specialty and role.

Appraisal supports this analysis but does not make the destination decision. An appraiser can help the doctor reflect on scope, evidence and development. Acceptance of an appraisal portfolio does not prove readiness for a Specialist application, formal training selection or Portfolio Pathway outcome. The relevant panel, employer, education body or GMC applies its own standard. Use appraisal to improve the plan, not to borrow authority it does not possess.

Create a current-scope statement in one page. For each domain, state the work regularly undertaken, the level of decision, frequency, boundaries, evidence location and development need. Date the statement. Avoid

copying a curriculum wholesale and ticking everything. A credible statement contains limits: Sara has strong independent clinical practice in her defined service and regular governance contribution, but limited experience of designing improvement across organisational boundaries and no formal role supervising doctors over time.

The statement also exposes hidden strengths. A doctor may coordinate complex discharge decisions, support less experienced colleagues and adapt a pathway every day without naming these as leadership. Translate ordinary work into accurate capability language, then find primary evidence. Do not inflate coordination into executive authority or routine advice into formal supervision. Recognition begins with precision.

Benchmark level through decisions, complexity and accountability. What does the doctor decide without prior approval? Which uncertainty do they manage? When do they seek another opinion? What consequences follow? How widely does the work influence practice? A high volume of familiar cases may demonstrate reliability without showing breadth; one dramatic case may show judgement without establishing consistency. Select a representative body of evidence.

Ask what work is absent from the current scope. A doctor in a narrow but autonomous post may be highly capable within it while lacking exposure required by a broader destination. The correct response is not to discount the current expertise or claim untested breadth. Name the difference and decide whether the destination requires a planned extension, formal training, a second setting, or evidence that current work already addresses the criterion in another way.

Create a boundary statement alongside strengths: matters routinely managed; matters managed with available advice; matters referred because another professional or service takes responsibility; and matters outside current practice. Panels and supervisors can then see that autonomy includes knowing limits. This is stronger than presenting escalation as evidence of deficiency or pretending that senior practice has no boundary.

## Capability gap analysis

A gap is the distance between evidenced current practice and the requirement of the chosen destination. It is not a list of everything a doctor could possibly learn. Retrieve the live framework, person specification, curriculum or appointment criteria and date the version used. For a Specialist post, the generic capability architecture can help organise preparation, but the applicable national documents and the actual vacancy remain controlling. NHS Employers' SAS development guidance

emphasises development aligned with service and individual needs, supported through appraisal, job planning and organisational structures.[89] Availability and funding are not uniform across the UK.

Build the analysis across six practical domains: clinical practice and judgement; quality, safety and governance; leadership and teamworking; education and supervision; communication, equality and professional values; and scholarship, research or improvement where relevant. These headings are a working map, not a claim that every destination uses identical labels. Add specialty-specific capabilities from the actual source.

For each requirement, record one of four states. **Demonstrated** means current, relevant evidence supports the level. **Partly demonstrated** means some elements or settings are missing. **Opportunity absent** means the doctor has not been allowed suitable work from which to develop or demonstrate it. **Development required** means further knowledge, skill or supervised practice is needed. The distinction between the final two states matters. A doctor cannot evidence leading a completed improvement cycle if no project time or data access was provided, but absence of opportunity does not prove capability.

Sara's clinical domain is mostly demonstrated through defined scope, peer review and governance outcomes. Her education record shows frequent teaching, yet little curriculum design, learner assessment or follow-through. This is partly demonstrated, not absent. Her improvement leadership is opportunity absent: she has presented concerns, but the service has not agreed a project remit, data support or authority. She needs both a developmental task and organisational conditions.

Write each gap as an observable outcome. Replace "gain leadership skills" with "lead a defined improvement project from agreed baseline through intervention and review, including stakeholder disagreement and sustainability". Replace "do more teaching" with "design a six-session programme from identified learner need, gather feedback, adapt delivery and obtain informed observation". Observable outcomes point to work and evidence; broad aspirations point mainly to courses.

Prioritise dependencies. Some gaps block the route: a required qualification, scope or evidence type. Others strengthen competitiveness but need not delay every step. Some activities satisfy several needs. A well-designed improvement project may generate evidence of governance, leadership, communication, data interpretation and reflection. This is efficient when the project is genuinely useful to the service, not when ordinary work is artificially relabelled to fill portfolio rows.

Use a red-amber-green view carefully. Red should mean a defined requirement not yet met, not personal failure. Amber means evidence or opportunity needs strengthening. Green means adequate against the present standard, with maintenance required. Attach a source and review date. A green judgement based on an old person specification may become irrelevant when the actual vacancy differs.

Bias and unequal access must be considered without assuming every unfavourable outcome proves discrimination. Ask whether opportunities, information, acting roles, mentorship and development time are distributed transparently. Record applications and responses. If a pattern raises concern, seek appropriate organisational, trade-union or equality advice. The practical response is evidence, not resignation to informal gatekeeping or an allegation unsupported by facts.

The capability development plan can use seven columns: destination requirement; current evidence; status; missing element; agreed activity; support or dependency; and review evidence. The NHS Employers template for collating Specialist entry-criteria evidence illustrates the value of criterion-led preparation, although the live vacancy and nation-specific requirements remain controlling.[91] Sara completes one row for education. The requirement concerns planned supervision and learner development. Her current evidence covers teaching delivery and feedback. The missing elements are supervised assessment and follow-through with learners. The agreed activity is co-supervision of two doctors over six months, with an experienced educational supervisor reviewing objectives, meetings, feedback and escalation. The evidence will be authorised records of the role, informed observation, anonymised process evidence and a supervisor's specific confirmation.

Her improvement row is different. Current evidence shows incident review and governance participation; it does not show end-to-end leadership. The activity is the transition project agreed in the next section. Dependencies include data access, authority to convene the team and protected time. If the employer does not provide them, the quarterly review should record an opportunity constraint rather than quietly mark Sara as having failed to complete the project.

Add a maintenance column for existing strengths. Progression planning can become so preoccupied with gaps that core clinical capability receives no attention. Record how essential skills, breadth and governance engagement will remain current while development work expands. If the plan undermines safe performance in the substantive job, its design is wrong.

Finally, distinguish a gap that needs experience from one that needs evidence retrieval. Sara initially marks clinical governance amber because her portfolio contains little material. Her minutes and approved reports show that she has already analysed incidents and changed a protocol. The task is to describe contribution and obtain authorised evidence, not invent another project. Correct classification prevents unnecessary work.

## Create opportunity through the job plan

Development becomes real when work, time, supervision, resources and evidence are agreed. The job plan is therefore not only a record of current service; it can be the operating agreement for capability development. Chapter 6 explains the contractual process. Here the task is to convert each priority gap into a proposal the service can evaluate.

Use five components. First, name the capability outcome. Second, describe the activity that could produce it. Third, identify supervision, authority, data, facilities and time. Fourth, define the deliverable and evidence. Fifth, set review dates. For Sara's improvement aim, the proposal is not "give me leadership SPA". It is to lead a defined review of a recurring transition problem, with an agreed sponsor, analyst access, stakeholder meeting time, a tested intervention and a six-month evaluation.

Make the service value explicit but credible. Explain the problem being addressed, who is affected and how the proposed development contributes. Avoid claiming savings or patient benefits before evidence exists. The organisation may reasonably prefer another priority; ask what alternative activity would develop the same capability. A rejected project does not have to end the development objective.

The conversation might begin: "My agreed progression aim requires evidence of leading improvement from problem definition to sustained review. My current duties allow governance participation but not ownership of a full cycle. I propose the following project, with these outputs and review points. I need agreement on remit, named supervision, data access and the time recorded in the job plan. If this project is not suitable, I would like us to identify an equivalent opportunity and document the decision."

Keep development and unpaid goodwill separate. Some learning occurs naturally within clinical work; some roles require identifiable supporting activity. Do not assume every aspiration creates an entitlement to a particular allocation. Equally, do not allow a substantial recurring responsibility to remain invisible because it began as an opportunity. Record actual work, review workload and seek agreement before an occasional task becomes a permanent second job.

Where the employer cannot provide an experience, consider a secondment, cross-site project, educational role, professional body, supervised external session or collaborative improvement work, subject to approval and governance. Clarify indemnity, confidentiality, time, conflicts and ownership of outputs. An external badge without meaningful work will not repair the gap. The activity must allow the doctor to perform and demonstrate the relevant capability.

Sara agrees a staged project and a supervised educational role. Her job plan records purpose, expected time, outputs and quarterly review. The arrangement does not promise regrading. It provides a fair opportunity to develop and creates contemporaneous evidence for a later decision.

Prepare for three employer responses. If the proposal is agreed, confirm start conditions and review. If it is partly agreed, identify which capability can still be developed and what remains outstanding. If it is declined, ask for the service reason, alternative opportunity and date for reconsideration. A courteous written summary might say: "Thank you for discussing my development plan. We agreed that the proposed cross-service project cannot begin this quarter because analyst support is unavailable. We will identify a smaller supervised project by 30 November and review the original proposal in March. Please let me know if this does not reflect our discussion."

Development funding should be checked in the reader's nation, organisation and year. National initiatives and local budgets change; an earlier colleague's award does not create a current entitlement. Ask what the fund covers, who is eligible, whether employer approval is needed, how leave and expenses are treated, and what happens if dates move. Build the plan so that a delayed course does not halt every capability outcome.

Opportunity also requires psychological and practical safety. Acting beyond present competence merely to create evidence is not development. Agree the decision boundary, accessible senior support and what happens when complexity exceeds the planned learning activity. The aim is progressively supported responsibility, with evidence of judgement and escalation, not a performance of independence.

## Mentors sponsors supervisors and advocates

A mentor helps the doctor think, test assumptions and make choices. They need not control opportunities or assess competence. A sponsor uses organisational credibility to make suitable opportunities visible and may recommend a person for consideration; sponsorship should not bypass fair selection. A supervisor observes or oversees defined professional activity and can give evidence-based feedback. An SAS tutor or education lead may

coordinate development support. An SAS advocate can identify structural barriers and influence organisational attention. A line manager or clinical lead controls particular service decisions but cannot automatically fulfil every developmental role.

Name the function before choosing the person. "I need a senior colleague" can produce an amiable but purposeless relationship. Sara needs a supervisor for direct feedback on improvement leadership, a sponsor who can help her access a cross-service forum, and a mentor to challenge whether the Specialist route still matches her goals. One person might perform two functions, but conflicts should be recognised. A supervisor whose assessment will determine progression may not be the safest person for wholly exploratory conversation.

Agree boundaries and cadence. What is the purpose? How often will you meet? What preparation is expected? What may be documented or shared? When will the arrangement end or be reviewed? Mentoring should not become indefinite emotional dependence; supervision should not be inferred from occasional corridor advice. Keep a short action note without recording confidential personal discussion unnecessarily.

Choose people for relevant knowledge, observation and willingness to be candid, not title alone. A consultant may understand specialty breadth; a senior SAS colleague may understand the destination and organisational barriers; a non-medical leader may observe multidisciplinary change more directly. A panel will value evidence from somebody positioned to know the work, rather than prestige detached from observation.

The doctor remains responsible for the plan. A mentor does not own deadlines. A sponsor cannot guarantee appointment. A supervisor cannot manufacture opportunity. If meetings repeatedly produce encouragement but no observable next action, restate the requested function or change the arrangement.

Use a relationship map to avoid dependence on one powerful supporter. List who understands the clinical work, who can provide observation, who controls access to opportunities, who offers confidential challenge and who understands the destination process. A diverse map reduces the risk that one departure collapses the entire plan. It also exposes when all endorsement comes from people who have never directly seen the work.

Reciprocity matters. Arrive prepared, complete actions, respect time and update supporters on outcomes. Sponsorship is easier when the doctor's work and readiness can be described accurately. Do not ask a sponsor to conceal a gap or influence a process improperly. Their most useful

intervention may be ensuring that the doctor is considered for a transparent opportunity, not securing the outcome.

## Evidence of impact

Attendance shows presence. Participation shows involvement. Contribution shows what the doctor did. Result shows what changed. Learning shows how judgement developed. Sustained impact asks whether the change continued or transferred. A strong portfolio moves through these levels without claiming more than the evidence permits.

Use the sequence: situation, responsibility, action, result, learning and next step. Define the initial problem and baseline. State the doctor's agreed responsibility among other contributors. Describe choices and action, including resistance or adaptation. Present the result with an authorised measure or informed observation. Explain limitations and what was learnt. Record whether the result persisted and what follows.

For Sara's teaching programme, attendance registers and slides confirm delivery. Learner feedback helps assess experience but not necessarily changed practice. Her stronger evidence includes the identified need, programme design, observed teaching, change made after feedback, assessment or follow-up appropriate to the programme, and confirmation of her contribution. If patient outcomes were not measured, she does not claim them.

For improvement, minutes can show responsibility and aggregate data can show change. A 20 per cent improvement means little without the denominator, definition, period and counterfactual limitations. State whether other changes occurred. If the measure worsens, the project may still demonstrate capability when the doctor identifies why, adapts appropriately and learns. Progression evidence is not a publicity brochure.

The generic Specialist capability framework is intended to support consistent understanding of the senior role, but evidence must be applied to the actual post and context.[90] Do not produce one example per heading and assume completeness. Test breadth, recency, level and consistency. A single successful project can be valuable without proving sustained capability across all leadership situations.

Build evidence during the work. Agree how contribution will be recorded, how data can be used, who can verify activity and what approvals are needed. Waiting until a vacancy appears leads to retrospective letters and lost records. Chapter 12's master index should link the primary item, explanation and permissible use rather than duplicating confidential material.

Sara's project initially produces no improvement in the chosen measure. The team discovers that its intervention depends on information another service cannot supply reliably. Sara records the result, convenes a review, narrows the intervention and negotiates a feasible data transfer. The second cycle improves reliability, although follow-up is short. Her evidence demonstrates more than a favourable number: she tested an assumption, handled disappointment, changed course and described the remaining uncertainty. This is mature impact evidence.

An interview or panel account can condense the project without making it simplistic. State the problem and baseline; Sara's defined responsibility; one difficult decision; the action taken with others; measured result; limitation; and what she would transfer to the new role. Keep the underlying evidence indexed. A concise account is persuasive when it rests on detailed work, not when it replaces it.

Compare evidence across time. One teaching observation and one project may establish promising capability. Repeated application in different contexts can show consistency and transfer. Do not postpone every application until the portfolio feels perfect, but identify which criteria require sustained evidence and which can be tested at selection. Read the actual standard rather than inventing a universal number of examples.

## A realistic progression timetable

A twelve- to twenty-four-month plan should contain dependencies, not a calendar filled with courses. Begin with the destination decision and live criteria. In quarter one, complete the scope statement, gap analysis, source check and opportunity conversation. Secure the essential work, supervision and job-plan conditions. Stop low-value activity that competes with the plan.

In quarters two and three, perform the agreed work. Capture contemporaneous evidence, seek feedback early and correct design problems. Review workload: a development project that repeatedly occurs at night because service work consumes the agreed time is not operating as planned. Escalate or redesign before exhaustion becomes the hidden price of progression.

In quarter four, test evidence against the destination. Ask an informed reviewer to identify unsupported claims, gaps in breadth and weak verification. Update the appraisal and development plan without asking the appraiser to certify eligibility. Decide whether to proceed, extend, change the opportunity or select another route.

The second year should deepen rather than merely repeat. Demonstrate sustained practice, wider application or a more complex level where required. Obtain current destination documents. For competitive recruitment, map the actual person specification. For Wales or Scotland regrading, use the current policy examined in Chapters 15 and 16. For England or Northern Ireland Specialist posts, follow Chapter 17. For specialist registration, rebuild the map from the live GMC specialty specific guidance as Chapter 18 explains.

Use quarterly questions: Is the destination unchanged? Which requirement has moved from absent to evidenced? What activity produced that evidence? Which employer dependency remains unresolved? What is consuming time without serving the destination? What must be verified before the next decision? Record decisions and owners, not only reflections.

Retain alternative destinations. Sara's primary route depends on the current Scottish policy and organisational assessment. If timing changes, the improvement and education capability remains useful in her existing role and for later competitive appointments. Her plan therefore has a minimum successful outcome: deeper, evidenced practice with a sustainable job plan. It also has a route-specific outcome: readiness to submit under the operative progression policy. Neither is described as guaranteed.

Set stop rules. Pause if the governing requirements are unclear, the activity creates unsafe workload, necessary supervision is absent, evidence would breach confidentiality, or the plan has become a collection exercise detached from wanted work. Seek individual advice where contractual rights, equality, immigration, health or a disputed selection decision materially affect the route.

At each six-month point, make one of four explicit decisions: continue as designed; continue with changed activity; defer the route while preserving useful development; or choose another destination. Record the reason. This protects against sunk-cost thinking, where years already spent collecting material become the main reason to continue towards work the doctor no longer wants.

Plan the application period itself. Reserve time to obtain the current documents, confirm eligibility, select examples, contact referees and review consequences for the present service. Do not rely on a promised vacancy or policy window until it is formally available. If a route uses a national form, work from the current official version and retain the version submitted.

The plan should include a conversation about recognition in the present role. Progression work may reveal that Sara already carries responsibilities absent from her job description or job plan. Correcting those records is

valuable even if the next grade is delayed. Use the Chapter 6 method to distinguish present contractual work from future development and from temporary acting arrangements.

At the end of the plan, Sara can answer five questions. What destination did I choose and why? What is my present evidenced scope? Which gaps remain? What opportunity, support and time were agreed? What decision am I now ready to ask for? This is progression made visible. It does not depend on a training number, and it does not imitate a consultant career as the only model of success.

The deeper principle is that development should leave the doctor with more capability and the service with better-supported work, whether or not a title changes at the anticipated moment. A career plan that produces only certificates is fragile. A plan that aligns purpose, opportunity, evidence and review can support several futures without pretending they are the same destination.

Chapter 15

# Regrading to Specialist in Wales

## The Wales policy and its status

Eleri, the composite senior Specialty Doctor introduced earlier in the handbook, independently manages a defined stream of complex clinical work in an NHS Wales service. Her job plan records clinics, multidisciplinary decisions, governance work and supervision. Colleagues routinely turn to her for judgement within that scope. When she asks how the role might be recognised as Specialist employment, the first answer she receives is that no Specialist vacancy exists and no budget has been identified. Those statements would be decisive in an ordinary recruitment exercise. They do not, by themselves, answer the questions created by the national Welsh regrading policy.

The controlling starting point is the *Policy for the Management of Specialty to Specialist Career Progression—Regrading*, approved in May 2025 by the Welsh Partnership Forum Medical and Dental Business Group. It arose after the Specialist role was introduced in the 2021 NHS Wales SAS contract reform. The policy provides a route through which an employed Specialty Doctor can ask to be assessed against the generic capabilities of the Specialist grade and against service need. It is a recognition and progression mechanism; it is not the process for competitive recruitment when a vacant or newly created role is to be advertised.[92]

This distinction determines the whole chapter. A doctor using the policy is not merely asking an employer to create a vacancy and allow them to compete. The policy says that, where the doctor demonstrates the required skills, experience and capability and the grade is required against service need, the doctor will progress to the Specialist grade. The word *automatically* appears in the policy's statement of principle. It should not be read as meaning that length of service alone produces an automatic change. It describes the consequence when the two substantive conditions have been established through the policy process.[92]

Applications are submitted through the Central Specialty Doctor Career Progression Portal administered by NHS Wales Employers. The public NHS Wales Employers resource hub and the May 2025 policy were rechecked on 12 September 2026; the hub continued to link to the central submission form, an official Word version useful for preparation, the policy, the Specialist terms and conditions and related resources.[4][92][93] Forms and

portals can change more quickly than the policy. Before acting, retrieve them from the current employer hub rather than relying on an old saved link or a colleague's previous application.

This route belongs to Wales. Specialist is an employment grade here; it does not mean that the doctor is entered on the GMC Specialist Register. Successful Welsh regrading does not confer specialist registration, a certificate of completion of training or automatic eligibility for every consultant appointment. Conversely, a doctor does not need to obtain Specialist Register entry before the policy can apply. The decision concerns the employment grade, the work being undertaken and the service's need for that level of responsibility.

The status check at the front of every application should record five items: the policy title and approval date; the version downloaded; the public source page; the form or portal used; and the date each was checked. Add the applicable contract, present job description and signed job plan. This record makes it possible to distinguish a national requirement from a local instruction and to resolve later questions about which form was submitted.

The policy provides the framework, while the employer still supplies evidence and decisions about the actual service. A Clinical Director may know the workforce model; medical workforce staff may administer the process; a panel evaluates the application. No single local participant should silently replace the national tests with a different test such as whether a funded vacancy already appears on an establishment list. Equally, the policy does not allow an applicant to declare the service need merely by declaring their capability. Both elements need evidence.

## Who the route covers

The policy's scope states that it applies to all existing and new Specialty Doctors employed within NHS Wales, whether on the 2008 or 2021 contract. A doctor should therefore establish the substantive employment grade from the written contract rather than from a rota label, email signature or locally convenient title. A locally employed doctor doing similar work is not thereby brought within this policy; nor is a doctor employed outside NHS Wales. An Associate Specialist remains on a distinct closed grade and should obtain advice about any proposed contractual move rather than assuming the Specialty Doctor route applies.[92]

The eligibility section includes parallel wording for medical and dental registration and primary qualifications. It requires full registration and a licence to practise with the GMC, or full registration and a licence to practise with the GDC. However, the scope and much of the operative wording refer

to Specialty Doctors. A dentist considering reliance on the policy should therefore use the current dental documentation and seek confirmation from the policy owner or employing organisation about coverage, rather than treating the medical route in this chapter as a complete dental guide.

For a medical applicant, four requirements appear in the policy. The doctor must have full GMC registration and a licence to practise. They must have at least twelve years' work, continuously or in aggregate, since obtaining the primary medical qualification. They must have at least six years in a relevant specialty in the Specialty Doctor or closed SAS grades; equivalent relevant-specialty experience in other medical grades, including overseas, is accepted. They must also meet the Specialist grade generic competencies framework.[92]

The two time tests do different work. The twelve-year test begins with the primary qualification and concerns work accumulated since then. The six-year test concerns experience in the relevant specialty and permits recognised equivalent experience from other grades and overseas. Do not simply subtract two dates and call the result eligible. Build a chronology showing role, specialty, employer, country, grade, full-time or less-than-full-time status, any gaps and the documents supporting each period. Where periods overlap, do not count the same time twice. Where the relevance of a role is not obvious, explain what clinical field and work it contained.

The policy does not say that all twelve years must have been in NHS Wales, or that all six relevant-specialty years must have been under a UK SAS title. That matters for internationally trained and career-changing doctors. It does not remove the need to demonstrate the quality, relevance and currency of the experience. A certificate of employment may establish dates; a job description, supervisor confirmation and practice evidence may be needed to show what the role involved. Translation and verification should follow the current form's instructions.

Eligibility is not seniority alone. Twelve years since qualification and six years in the specialty do not establish the generic capabilities. Nor does being at the top of a Specialty Doctor pay scale. The policy says career-development discussions should occur continuously through appraisal and job planning, especially when the doctor reaches the higher pay progression threshold, but this is a trigger for considering development rather than a substitute eligibility test.[92] Pay progression within the Specialty Doctor grade and progression to Specialist are separate contractual decisions.

Working part time, taking family or health-related leave, or having a career break should not be converted casually into a negative inference about capability. The policy uses aggregate service language for the post-

qualification period. The applicant should present an accurate chronology and current evidence; the employer should apply the policy fairly and consider relevant equality obligations and reasonable adjustments. A doctor who needs the form, meeting or interview adjusted should ask early and record the practical requirement without feeling obliged to disclose unnecessary medical detail.

Complete an eligibility page before building a large portfolio. Record: current substantive grade and contract; GMC registration and licence status; primary qualification date; qualifying work chronology; relevant-specialty chronology; and the evidence location. Mark uncertainty rather than concealing it. For example: “Overseas role, August 2010 to July 2013—specialty relevance evidenced by job description and employer confirmation; panel clarification requested about six-year calculation.” This makes a precise question possible.

If a doctor is not yet eligible, the sensible output is a dated readiness plan, not a speculative application. Identify the earliest possible date on the verified chronology, the capability development still needed and the service evidence to maintain. The route remains one possible career choice. It should not pressure every experienced Specialty Doctor to seek a grade change or imply that remaining in a valued Specialty Doctor role is failure.

## Capability and defined scope

The Welsh policy uses the generic Specialist grade capability framework. Its six broad domains cover professional values, behaviours, skills and knowledge; leadership and teamworking; patient safety and quality improvement; safeguarding vulnerable groups; education and training; and research and scholarship. The framework describes high-level capabilities that can apply across specialties, while the applicant's evidence must show how they operate in the defined role.[6]

Defined scope is the organising idea. A Specialist may exercise senior, independent or autonomous judgement within an agreed area of practice without being required to demonstrate the whole breadth of a consultant curriculum merely because both roles can involve autonomy. The framework itself describes autonomy as operating to defined competencies within local clinical governance. An applicant should therefore begin with the patients, procedures, decisions, settings and boundaries of the work for which recognition is sought. Scope that is clear is not scope that is diminished.

For Eleri, “independent practice” would be too vague. Her scope statement identifies the referral population, the clinics she conducts, the

complex decisions she makes, the circumstances in which she obtains another opinion, her contribution to cross-site pathways and the governance structure in which her work is reviewed. It also states what she does not undertake. That final boundary increases credibility: safe senior practice includes recognising limits and escalating appropriately.

Map each capability through three linked propositions: claim, evidence and impact. A claim should be specific enough to test. “I lead” is weak; “I chair the weekly multidisciplinary review for this patient group and make the clinical prioritisation decisions within an agreed pathway” is assessable. Evidence might include the job plan, terms of reference, an authorised activity summary, multisource feedback and confirmation from someone who directly observes the work. Impact might show improved decision timeliness, clearer escalation or learning from an outcome. One document need not prove all three propositions.

Clinical evidence should demonstrate judgement, complexity, uncertainty and continuing responsibility, not merely volume. A logbook showing hundreds of cases may establish exposure. Selected, suitably anonymised case analyses can show how the doctor evaluated uncertainty, revised a plan, involved patients and colleagues, and responded to outcomes. Governance records can corroborate that the work sits within an authorised service. Avoid copying identifiable records into a personal bundle. Use approved summaries and the organisation's information-governance rules.

Leadership and teamworking do not require a formal management title. Strong evidence may show how the applicant coordinated professional contributions, handled disagreement, escalated a safety concern, redesigned a pathway or helped a team make a difficult decision. The claim must fit the evidence. Taking minutes is not leading the decision; attending a meeting is not demonstrating influence. Conversely, sustained clinical coordination should not be discounted merely because the doctor was never given a grand title.

Quality evidence should show a complete learning loop where possible: problem, baseline, intervention, evaluation and response. An audit certificate alone says little about the applicant's judgement or effect. If the result was neutral or adverse, an honest account of what was learnt can be more persuasive than an inflated success claim. The framework also includes acting on incidents, complaints, feedback and systemic risk. These can be evidenced without revealing confidential details.

Education evidence can include identifying a learning need, planning teaching, supervising, giving feedback, creating safe learning opportunities

and evaluating whether the intervention helped. It should distinguish teaching delivery from educational supervision or programme leadership. Research and scholarship can include critical appraisal, applying and communicating evidence, guideline development, improvement dissemination and engagement with research; the generic framework does not require every applicant to produce a conventional academic publication. [6] Evidence should match the role rather than imitate someone else's portfolio.

Create a capability matrix with one row for each framework item and five columns: narrow claim; current evidence; corroborator; effect or learning; gap or action. Limit the main application to the strongest material and use an index for supporting documents. Cross-reference precisely: “QI-03, approved report, pages 2–4” is useful; “see portfolio” transfers the work of interpretation to the panel. More pages do not cure a missing capability.

Test the matrix with a specialty-informed senior colleague who understands the work but has not helped write the application. Ask them to explain what they think the defined scope is and identify which claims remain unsupported. Their inability to find a point is evidence about presentation, not necessarily about the underlying capability. Revise the map before collecting yet more material.

Evidence also needs a date and a relationship to present practice. A strong example from many years ago may demonstrate development but not necessarily current capability. Pair older foundation evidence with recent activity, feedback or review. Where the service has changed, explain whether the same judgement is still exercised and under what governance. The purpose is not to discard a long career; it is to stop chronology being mistaken for currency. Appraisal records can locate continuing work, but the panel still needs evidence proportionate to the capability claimed.

Do not treat absence of opportunity as absence of potential. If a required domain is thin because the health board has not provided an agreed activity, record the requests and the organisational dependency. That may still leave a current evidence gap, but it makes the development need intelligible and supports a fair plan. The application should not pretend that intended future work is completed capability. It can show insight, preparation and a specific route to obtaining observable evidence.

## Service need

Capability and service need are related but separate. Capability asks whether Eleri meets the requirements of Specialist practice within her defined scope. Service need asks whether NHS Wales requires a Specialist post for the

work. Personal aspiration, fairness and retention may all be relevant context, but none replaces an evidence-based account of what the service requires.

The Welsh policy gives a particularly important rule. Where a Specialty Doctor can evidence that they are already working wholly or partially at the level of clinical responsibility of a Specialist, that is to be taken as sufficient evidence of service need. The policy gives independent outpatient clinics or theatre lists, including work under a named consultant, as non-exhaustive examples.[92] "Partially" matters. The doctor need not show that every activity is already Specialist-level before existing higher-level responsibility can satisfy this service-need proposition.

Do not turn that rule into a circular assertion. Describe the work: responsibility, frequency, population, decisions, governance and consequence if it is not performed. Link it to the job plan and activity record. If the responsibility is current but missing from the written plan, say so and request a job-plan review. The written record may need correction, but omission from it does not make the work imaginary. Equally, an occasional exceptional act does not necessarily establish a recurring service requirement.

The policy also recognises another route to service need. A doctor may not currently be working at the Specialist level of clinical responsibility but may otherwise meet eligibility, while the department has an evidencable need for a Specialist. The policy offers gaps in the senior rota or a need for more autonomous clinicians as examples.[92] Here the service case must identify the missing function and why Specialist-level responsibility is the appropriate response. It should not simply state that the department is busy or short staffed.

A useful service-need statement has seven elements. First, define the patient or service function. Second, identify the work and level of decision required. Third, show frequency and durability rather than a transient pressure. Fourth, show current delivery, gap or dependency. Fifth, explain the governance and escalation needed. Sixth, identify relevant workforce plans, demand or risk evidence. Seventh, distinguish this evidence from any proposal about how budgets should be moved. The policy requires service need; it does not require the applicant to solve the employer's entire financial plan.

Eleri obtains her signed job plan, clinic schedules, pathway terms of reference, authorised aggregate activity information and minutes confirming responsibility for a recurring governance function. Her statement describes a defined service already delivered, not a wish list for unrelated higher duties. She avoids claiming that only she could perform it. The need belongs to the

service; her capability is the separate reason she may progress into the required role.

"There is no budget" is not a complete policy answer. The policy expressly states that lack of identified budget alone for the increased cost of regrading is not a reason for refusal.[92] This does not mean resources are irrelevant to implementation or that the applicant controls them. It means the panel's reasoning must address the policy conditions rather than substituting budget alone for analysis. A calm response is: "Please confirm whether capability, service need or both are disputed, and identify the evidence and policy provision relied upon."

"There is no established Specialist slot" also needs analysis. The regrading route would serve little purpose if every applicant first had to point to an already vacant advertised post. If current wholly or partially Specialist-level responsibility is established, the policy specifies how it is treated as service-need evidence. If the service need exists elsewhere in the health board rather than the current team, one of the policy outcomes addresses identification of a suitable post. That is different from pretending that every aspiration must be accommodated in the same place.

The service-need mapper should have two sides. The first records existing higher-level work: function, level, frequency, job-plan reference, evidence and governance. The second records unmet or future need: workforce plan, demand or risk, required level, location, duration and decision owner. Finish with two separate conclusions: "Capability proposition" and "Service-need proposition." Keeping those boxes apart prevents a strong case on one side from concealing a gap on the other.

Test contrary explanations. If the service claims the work can safely remain under a different grade, ask what responsibility, supervision and availability that model assumes. If the applicant claims the work is indispensable, examine cancellations, cover arrangements and outcome data. A credible statement acknowledges uncertainty and alternative designs, then explains why the evidence supports the Specialist function. It should also distinguish a requirement for senior medical judgement from shortages that might be addressed through administration, diagnostics, nursing, scheduling or a differently configured team.

## The line manager stage

The policy expects career development to be discussed through regular appraisal and job planning. Appraisal can identify learning and reflect on scope; job planning can record duties, resources and objectives. Neither is itself the regrading decision. The line-manager meeting begins the formal

conversation about using the policy once the doctor believes they can demonstrate eligibility.

Request the meeting in writing and identify its purpose. A concise wording is: “I would like a meeting under section 6.2 of the All-Wales Specialty to Specialist progression policy to discuss my readiness and proposed application. I will bring an eligibility chronology, capability index and service-need summary. Please confirm who should attend and the applicable current form.” This is clearer than requesting a general career chat and later assuming it was the policy meeting.

The meeting should be constructive and supportive. The doctor may request that the SAS Advocate attend.[92] Clarify the Advocate's role in advance: support, process clarification and help in maintaining a fair conversation are different from deciding the application or becoming the applicant's witness for every clinical claim. If independent employment representation may be needed, seek it through an appropriate union or adviser rather than assuming the Advocate replaces it.

Give the manager usable material before the meeting. A one-page role summary should state contract, working pattern, specialty, defined scope and request. The eligibility chronology shows the time tests. The capability index points to the main evidence. The service-need statement names the required work. A short questions page identifies anything requiring managerial confirmation. Do not send an uncontrolled archive and expect the manager to discover the argument.

If the manager supports the application, the policy says they should help complete the MST Specialty Doctor Career Progression Application Form and provide a statement explaining how they believe the eligibility criteria have been met.[92] Ask the manager to make that statement specific to what they know. Where another person has direct knowledge of a clinical activity, include appropriate corroboration rather than asking the manager to certify unseen work.

If the manager does not support the application at that time, they must confirm the position in writing and give reasons within five working days of the meeting. The reasons should focus on elements of eligibility that are not met or demonstrated. The response should identify development areas and an action plan to help the doctor meet the competencies within a defined period.[92] A statement such as “not ready” without the disputed criterion, supporting explanation and next step is not the detailed response contemplated by the policy.

Managerial non-support does not close the route. The doctor may still complete and submit the central form and is advised to include the written

reasons for non-support.[92] That option should be exercised thoughtfully. First check whether the disagreement is about evidence that can be clarified, a genuine capability gap, service need, or an unrelated objection. Record the meeting, correct factual errors and seek appropriate advice. A transparent submission is stronger than one that hides the manager's concern.

When a development plan is appropriate, write it as a shared plan with dependencies. For each gap identify the activity, supervision or assessment, protected time, responsible person, evidence product and review date. “Gain teaching experience” is not a plan. “Co-design four sessions for the multidisciplinary induction, receive observed feedback from the educational lead and review learner evaluation by 31 March” is testable. The employer's promised support should be recorded alongside the doctor's action.

End the meeting with a short control note: date; attendees; policy used; points agreed; disputed facts; documents to be supplied; responsible people; deadlines; and whether the application will proceed. Send it for correction. This is not adversarial minute-taking. It preserves a common account of the next steps and prevents later disagreement about whether support was promised or withheld.

## Central submission and panel assessment

The application goes to the Central Specialty Doctor Career Progression Portal administered by NHS Wales Employers. It is then forwarded to the employing health board's medical workforce team, which progresses the application. The team should confirm receipt to the doctor and line manager and set out the timescale for the next stage.[92] Save the submission confirmation, exact form and attachments. The submission date later matters to the effective date if the application or appeal succeeds.

Prepare offline before transferring material to the live portal. Build a master response in a controlled document, label evidence consistently and test every link or attachment. Check whether the online form imposes character limits or asks a question differently from an earlier Word copy. Do not paste identifiable patient narratives or confidential workforce papers simply because the portal accepts attachments. Use anonymised or authorised summaries and follow employer instructions.

A strong opening gives the panel a map: current grade and contract; verified eligibility chronology; defined scope; concise capability conclusion; concise service-need conclusion; and the progression requested. The remainder should allow the panel to trace those propositions. Use the language of the framework without copying whole sections of it. Each answer should tell the panel what the doctor does, what evidence

demonstrates it, what changed or was learnt and where the evidence can be found.

The health board identifies a panel within twenty working days. It must include at least one senior independent clinical lead, a staff member with clinical oversight of the team concerned and an HR member.[92] "Independent" modifies at least one senior clinical lead; it does not mean every panel member comes from outside the health board. If a conflict of interest is apparent, raise it promptly and factually, explaining the relevant relationship and requested safeguard.

The panel considers the application and may accept it, reject it or request further information from the doctor and line manager. Further information may include an invitation to discuss the application. No doctor should be rejected without first being invited to an interview, but an interview is not required for acceptance where the written application sufficiently demonstrates the case.[92] An invitation is therefore not evidence that rejection has already been decided; it is an opportunity to clarify the two tests.

Prepare for a panel discussion through evidence stories rather than memorised slogans. Select six to eight examples spanning clinical judgement, limits and escalation, leadership, improvement, education, scholarship and response to feedback. For each, be able to state the situation, your responsibility, your decision, the evidence, the result and what you learnt. Keep the answer within the defined scope. A confident admission that another service provides a procedure can demonstrate boundary awareness better than claiming universal expertise.

Anticipate questions about attribution. If Eleri says "I redesigned the pathway," the panel may reasonably ask who authorised it, who analysed the data and how the team contributed. She changes the claim to: "I led the clinical design work, coordinated the multidisciplinary test and presented the aggregate evaluation; operational implementation was approved and delivered jointly." Precision protects colleagues' contributions and makes her own contribution credible.

When further information is requested, create a response schedule. Record the exact question, material requested, lawful source, owner, due date and response location. If the request is unclear or disproportionate, seek clarification rather than guessing. If information cannot be supplied because it does not exist or cannot lawfully be disclosed, explain that and propose an alternative form of evidence. Do not manufacture retrospective assessments or invite a colleague to sign a statement they cannot verify.

The policy says all applications must be considered within twenty working days of the panel being convened.[92] That is not the same as twenty working days from submission. Read the receipt correspondence carefully: the panel must first be identified within twenty working days, and the application then considered within twenty working days of convening. Working-day targets may be affected in practice by requests and correspondence, but silence should not be allowed to erase the process. A proportionate follow-up quotes the recorded dates and asks for the current stage and revised timetable.

Use an application index with five fields: policy requirement; proposition; evidence identifier; exact location; and caveat or verification. Add a submission inventory recording filenames, dates and checksums if appropriate. The purpose is not technological sophistication. It is to ensure that the panel and applicant can identify the same version and that a later appeal can distinguish evidence actually submitted from material found afterwards.

Before submission, run three readings. The first is evidential: can every important verb be traced to support? The second is adversarial in the constructive sense: what would a careful panel need to clarify or doubt? The third is humane: can a reader unfamiliar with the specialty understand the service and the doctor's contribution without decoding local acronyms? Ask a trusted reviewer to perform one of these readings independently. Keep answers concise enough that the strongest evidence is visible.

An interview preparation sheet can use six prompts: define the scope in ninety seconds; give the strongest example of autonomous judgement; explain a boundary and safe escalation; demonstrate one sustained improvement; distinguish personal contribution from team achievement; and state the service need independently of personal aspiration. Add the evidence identifier beside each answer. This is a rehearsal aid, not an official scoring grid. The national policy does not publish a point score or prescribe these questions.

## Outcomes effective date and job plan

The Welsh policy describes four outcome patterns. Reading them as two findings—capability and service need—makes the logic clearer. The first outcome applies where both are satisfied: the doctor becomes a Specialist and a job plan is agreed to ensure that Specialist and Specialty service work are covered.[92] This is regrading under the policy, not appointment to the GMC Specialist Register.

If the doctor does not meet the capability criteria but the service need is confirmed, the second outcome requires support to develop the skills and competencies so that the doctor can reapply. The development plan should identify the actual gaps rather than send the doctor on generic courses. The policy says the health board should oversee and support a development plan for up to two years and may discontinue support if no significant progress is made.[92] Record objectives, employer dependencies and review points from the beginning.

If the doctor meets the criteria but the service has no requirement for an autonomous Specialist doctor anywhere within the health board, the third outcome directs operational and workforce teams to identify a suitable Specialist post into which the doctor can be slotted within a reasonable time. It also says recruitment for alternative autonomous practitioners in the same subspecialty may be suspended until the doctor is appropriately appointed.[92] The policy does not define “reasonable time” numerically. The written outcome should therefore identify who owns the action, what search or planning will occur and when progress will be reviewed.

If neither capability nor service need is established, the fourth outcome provides feedback on development but no further action unless workforce planning identifies a future need, in which case the development outcome is used. This is not a finding that the doctor's current work has no value. It is a decision on the evidence against this policy's two conditions. The doctor should compare the reasoning with the job plan and actual responsibilities, particularly if higher-level work continues after rejection.

For an accepted application, the date of regrading is the date the form was submitted to the central portal.[92] Retain the portal receipt because it anchors implementation. Confirm the new contract, grade, pay point and any arrears calculation in writing. The policy establishes the regrading date but does not reproduce every payroll calculation. Current Specialist terms, recognised service provisions and payroll records control the financial detail.[94]

A job-plan review may be needed if the existing plan is incompatible with the Specialist terms' working limits or if additional or different duties accompany regrading. The policy says this should not unduly delay the regrading.[92] Recognition does not give the employer permission to add unlimited duties without agreement. The revised plan should specify scope, sessions, locations, on-call work, supporting professional activity, objectives, resources, accountability and review. If the role already contained the higher-level work, the review may largely make that reality explicit.

Check what changes and what does not. The grade and contractual terms change. The doctor remains responsible for practising within competence and local governance. Appraisal and revalidation continue. Existing formal authority does not automatically expand beyond what is delegated or agreed. If management, educational or statutory responsibilities are proposed, their remit and support should be documented separately.

The outcome planner should list: written decision; capability finding; service-need finding; effective date; contract issue date; pay and arrears check; revised job plan; governance or credentialing action; appraisal and portfolio update; development support; and review owner. A successful decision is not fully implemented until these records agree. An unsuccessful decision is not usable until its reasons and next steps are sufficiently precise.

Pay deserves careful but bounded attention. A change to Specialist grade places the doctor on the applicable Specialist contractual scale, but the correct starting point and arrears can depend on the terms, implementation and recognised service. Do not calculate entitlement from an outdated online table or assume that the difference between the current salary and the first Specialist point is the whole effect. Ask payroll for the effective-dated calculation, pensionable-pay treatment and correction date; compare it with the contract and seek advice promptly if it appears wrong.

Where duties are to change, separate recognition of existing work from agreement to new work. Record which responsibilities justified the application, which are continuing and which are genuinely additional. Then test time, support and governance for each addition. This prevents the successful doctor being told that progression is conditional on absorbing a substantially enlarged service without a workable plan. The policy outcome and the job-plan discussion should reinforce each other, not be used to postpone one another.

## Feedback and appeal

An unsuccessful applicant must receive detailed in-person feedback, the reasons for rejection and, where relevant, the capability areas requiring improvement. That feedback should then be set out in writing.[92] Ask for capability and service need to be addressed separately. A general impression —“the panel did not feel the case was strong enough”—cannot reliably guide development or identify whether the policy was applied correctly.

Create a decision-analysis sheet with one row for each conclusion. Record the policy test, panel finding, stated reason, evidence submitted, apparent gap, factual disagreement, procedural issue and proposed response. Classify the problem before deciding what to do. A missing dated

confirmation may be curable evidence. Lack of recent practice may require development. A conclusion that budget alone defeats an otherwise accepted case may raise a policy question. These are not the same grounds.

The policy allows an unsuccessful applicant to appeal in writing within twenty working days of the written outcome, detailing the points in dispute.[92] The published Welsh text does not specify in section 7.1 the recipient to whom the appeal must be sent. Follow the outcome letter and current local instructions, and obtain confirmation of receipt. Do not lose the deadline while debating the decision informally.

The appeal panel must include an appropriate senior clinical lead, the SAS Advocate and a senior HR member. No member may have been involved in the original application. Where there is a conflict, a SAS Advocate from another health board may attend instead. The policy also says consideration should be given to advice from the relevant Royal College SAS representative where specialty or subspecialty knowledge would assist.[92] These safeguards support fresh consideration; they do not guarantee a different outcome.

Written submissions must be received one week before the appeal hearing. The doctor may present personally or with assistance, and expert witnesses may be included where necessary. The appeal decision must be given within fifteen working days of the hearing. If upheld, implementation is backdated to the date the application was submitted to the online portal.[92] The policy does not state a numerical period within which the appeal hearing itself must occur. Record correspondence and seek a timetable rather than inventing one.

An appeal should identify material points, not merely repeat the application. For each ground, state the disputed decision, relevant policy provision, evidence already submitted, alleged factual or procedural error, why it could affect the outcome and the remedy sought. If new evidence post-dates the decision, distinguish it from evidence the original panel overlooked. Obtain union or legal advice where the employment consequences are significant.

Confidentiality still applies. Use permitted, minimised evidence and secure submission routes. Do not identify patients or disclose internal papers to an external adviser without an appropriate basis. The fact that a document may support an appeal does not itself authorise copying. Ask the information owner for an approved extract or summary where required.

If appeal is not appropriate or does not succeed, convert the reasons into a reapplication plan. Preserve the original decision and submitted bundle, update capability and service-need evidence, and address each previous

point explicitly. Reapplication is not an admission that earlier work lacked value. It is a later decision based on a clearer or changed record.

Ask what remedy the ground logically supports. If relevant evidence was overlooked, reconsideration of that evidence may be appropriate. If an ineligible panel member participated, a fresh panel may be needed. If the reason is a genuine capability gap, development and later reapplication may be stronger than an appeal. The applicant does not have to choose alone: a union representative can advise on employment process, while a trusted specialty colleague can test the clinical evidence. Preserve the appeal deadline while seeking that advice.

## Complete preparation case

Eleri begins with the policy rather than the refusal language. Her contract confirms that she is a Specialty Doctor employed in NHS Wales. Her chronology shows more than twelve aggregate years since primary qualification and more than six relevant-specialty years, including an overseas period supported by a job description and employer confirmation. She records full GMC registration and a licence to practise. She then defines the clinical stream for which she seeks recognition, including boundaries and escalation.

Her capability matrix uses eight main evidence stories rather than hundreds of attachments. Clinical records demonstrate complex independent decisions through approved summaries. A governance report shows her response to recurrent risk. Multisource feedback supports teamworking. A teaching programme shows design, feedback and revision. A guideline project demonstrates appraisal and communication of evidence. Each claim identifies her contribution and the evidence location.

Her service-need statement shows that she already carries part of the clinical responsibility at Specialist level, recorded across the job plan, clinic schedules and pathway governance. It also identifies a recurring senior decision gap when she is absent. The manager initially says no budget or slot exists. Eleri asks which of capability and service need is disputed and draws attention to the policy's treatment of existing partial Specialist-level work and budget alone. She sends a factual note after the meeting.

The manager supports some capabilities but remains uncertain about research and scholarship. Together they add specific corroboration showing how Eleri appraised evidence and led adoption of a revised guideline; they do not invent a publication requirement. The manager submits a focused statement. Eleri transfers the checked responses to the central form, removes

identifiable material, saves the exact bundle and records the portal receipt date.

The panel requests clarification about the extent of autonomy and invites her to interview. Eleri explains what she decides, what governance authorises, when she escalates and how the service uses the role. She credits the multidisciplinary team and does not claim whole-specialty breadth. The panel accepts both eligibility and service need. Her regrading takes effect from the portal submission date. A job-plan review records the existing Specialist responsibilities and adjusts supporting work; payroll confirms the contractual change and arrears separately.

The case is not a promise that every well-prepared application succeeds. It demonstrates control of the process. Eleri used the correct national route, separated capability from service need, turned an initial budget objection into a policy question, protected confidentiality and preserved the submission trail. The Wales checklist is therefore short: verify scope and eligibility; map capabilities; write service need separately; hold and record the manager meeting; submit through the live central route; retain the exact version and receipt; analyse both findings; and protect the twenty-working-day appeal period. That is how apparent senior practice becomes a decision the policy can properly test.

If the outcome had instead identified a gap, the same records would still be useful. Eleri could convert the reason into an activity, support, evidence and review date, while ensuring that work said to exceed the current grade was addressed through job planning. A progression process is credible only when its negative decisions also produce intelligible action.

Chapter 16

# Regrading to Specialist in Scotland

## The Scottish policy source

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

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

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

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

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

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

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

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

## Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

## Specialist capability in Scottish context

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Starting the process

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

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

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

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

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

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

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

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

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

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

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

## Evidence and assessment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Timescales and decision

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

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

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

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

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

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

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

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

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

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

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

## Outcome job plan and pay

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

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

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

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

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

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

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

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

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

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

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

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

## Review appeal and reapplication

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

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

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

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

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

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

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

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

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

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

Chapter 17

# Competing for Specialist posts in England and Northern Ireland

## Competitive appointment and employer created posts

Priya and Omar are composite doctors. Both have worked for more than twelve years after their primary medical qualifications, and both have substantial NHS experience. Priya is a Specialty Doctor in England. She manages a defined group of complex patients autonomously within the service's governance arrangements, leads a recurring quality meeting, teaches several professional groups and has evaluated a change that she helped introduce. Omar is a Specialty Doctor in Northern Ireland. He has worked just as long, is highly trusted clinically and regularly keeps the service functioning when senior colleagues are absent. When similar Specialist posts are advertised, each assumes that long service will be the central proof of readiness.

It is not. Length of service supplies context, but an advertised Specialist post is filled through a competitive appointment process. The employer first decides to establish a post with a particular scope, resources and person specification. Eligible applicants then have to show that they meet the stated requirements and are the strongest appointable candidate under the employer's process. A doctor can already be practising at considerable seniority yet not be entitled to an uncreated post, automatic shortlisting or appointment. Conversely, a vacancy may be designed around a narrower defined area of practice than the doctor expected. The title alone cannot settle the match.

Three decisions must remain separate. The first is appointment to the employment grade called Specialist under the applicable national contract. The second is entry onto the GMC Specialist Register, which may follow an approved training route, the Portfolio Pathway or another recognised route. The third is regrading or progression under a national policy in Wales or Scotland. England and Northern Ireland do not acquire the Welsh or Scottish policy simply because all four nations use the word Specialist. A doctor may be appointed to a Specialist-grade post without being on the Specialist Register if the vacancy and person specification permit it. Specialist registration, discussed in Chapter 18, does not itself create or confer an NHS Specialist-grade job. [99][5]

The distinction changes preparation. If Priya wants the advertised employment post, her governing document is the live recruitment pack: advertisement, job description, person specification, proposed job plan and employer instructions. The national Specialist capabilities help her interpret the level expected, but they do not replace local criteria. If she wants specialist registration, the live GMC curriculum and specialty-specific guidance organise the evidence. If she wants a Welsh or Scottish regrading route, the operative national policy governs eligibility and process. One portfolio may provide material for all three destinations; it must be selected and explained differently for each.

Do not begin by asking whether you are ‘basically already a Specialist’. Begin with four concrete questions. Does an actual post exist? Which national contract is offered? What work has the employer defined? What evidence will its panel assess? This approach protects the doctor from two opposite errors. The first is self-exclusion because a colleague says the role is ‘consultant level’ without analysing the actual specification. The second is overconfidence based on title, years or informal praise when an essential criterion remains unsupported.

The employer’s design also deserves scrutiny. A genuine Specialist role should reflect a senior, independent or autonomous practitioner working within defined competencies and local clinical governance. It should not be a vaguely enlarged Specialty Doctor post carrying additional liability without corresponding authority, time or resources. Equally, the grade is not a device for renaming every experienced doctor. The post needs a coherent specialised scope and a person specification that identifies which capabilities are key at entry and which may be developed after appointment. National materials were constructed to help employers make that judgement rather than copy an undifferentiated list into every vacancy. [6]

Priya therefore treats the vacancy as both an opportunity and a proposal to be tested. Omar does the same. They ask what problem the organisation is trying to solve, which decisions the postholder will own, how the work connects to consultants and other senior clinicians, and what success would look like after a year. This is not suspicion. It is professional due diligence. A candidate can prepare a better application when the role is intelligible, and a service is more likely to appoint well when it can explain the role beyond the grade name.

## The national capability framework

The generic capabilities framework begins with the role’s core idea: the Specialist doctor provides expertise in a specialised area, whether in a

specific specialty or a generalist service, and can manage the full range of presentations in that defined area of practice. The final phrase matters. It does not require the breadth of every consultant post in an entire specialty, but it does require more than a collection of selected tasks performed only when others are immediately available. Scope and autonomy have to be defined together. [6]

The framework groups capability across professional values, skills and knowledge; leadership and teamworking; patient safety and quality improvement; safeguarding; education and training; and research and scholarship. These are not six decorative headings for an application. They describe different forms of work. Clinical expertise concerns assessment, judgement, management, uncertainty and recognition of limits. Leadership concerns decisions, relationships, challenge and adaptation. Quality concerns action on risk, improvement cycles and learning. Education concerns creating and evaluating learning, not simply delivering slides. Scholarship concerns appraisal and use of evidence, not necessarily possession of a research degree.

Translate each domain into a claim-evidence pair. For clinical judgement, identify the population and setting, the decisions made, boundaries of competence, access to help and evidence from actual practice. For teamworking, choose an example in which professional differences mattered and show how you obtained a decision or safer plan. For quality improvement, retain the baseline problem, your contribution, the change tested, results and what happened afterwards. For education, distinguish teaching attendance, teaching delivery, supervision, assessment and programme leadership. For scholarship, show how evidence altered practice or informed a decision rather than listing journal articles read.

Capability is demonstrated at the relevant level through several forms of evidence. The national person-specification template gives examples including job plans, logs, audit of personal practice, colleague references, appraisal and job-planning evidence, feedback, quality work, teaching records and interview. It also makes a crucial distinction: some capabilities need to be fully present and evidenced at appointment, while others may be developed in the role. Employers should identify what is key for the particular post and what is required but not key. Candidates should therefore resist both extremes—assuming every framework statement must be separately proved in identical depth, or assuming a generic statement of seniority covers them all. [100]

Use the framework as a diagnostic map before applying. Mark each capability in one of four states: directly required by the vacancy and strongly

evidenced; required but evidence needs preparation; prospectively developable under the specification; or apparently irrelevant or unclear. The last category requires clarification rather than silent deletion. A service may omit formal research leadership but still expect critical use of evidence. It may require supervision without specifying whether educational-supervisor recognition is essential at entry. The candidate needs to know what the wording means in that employer's process.

Evidence should show level as well as participation. A certificate from a leadership course records learning activity. It does not prove that the doctor led a difficult service decision. Minutes naming the doctor as chair may prove presence and role, but not the quality or effect of leadership. A concise account can bring several records together: what responsibility Priya held, the competing interests, the decision she made or influenced, the result, what she learnt and how this prepares her for the advertised responsibility. The underlying documents should support rather than merely decorate that account.

Autonomy must also be described safely. The framework recognises senior independent or autonomous practice within defined competencies and local governance. No responsible senior doctor works without boundaries, collaboration or escalation. A candidate who says 'I never need help' demonstrates poor judgement, not independence. Strong evidence identifies when the doctor acted without routine supervision, how complexity was managed, when advice was sought, and how the system made escalation available. The same description helps a panel distinguish mature autonomy from unsupported lone working.

The capabilities overlap, but do not collapse them into a single heroic story. Priya's pathway project may demonstrate clinical reasoning, multidisciplinary leadership, patient involvement, improvement and teaching. She should make her contribution clear and cross-reference the project where the application permits, while retaining other examples. One project rarely demonstrates the full range of a senior role. Panels need confidence that capability is sustained across ordinary work, not confined to the candidate's most successful month.

An honest gap does not always end an application. Read the vacancy wording. If a capability is desirable, or explicitly intended for prospective development, show adjacent experience and a credible plan. If it is essential at appointment, do not relabel potential as completion. Contact the named person before the deadline where interpretation is genuinely unclear. A short, specific enquiry about the criterion is more useful than asking whether the candidate is 'senior enough' in general.

Omar discovers this when the Northern Ireland template identifies educational capability but the local job description emphasises clinical supervision rather than formal educational supervision. He has observed and supported doctors in practice, provided feedback and escalated concerns, but he is not a recognised educational supervisor. His application states precisely what he has done. Before applying, he asks whether formal recognition is an entry requirement or planned development. He neither hides the gap nor allows an ambiguous phrase to exclude him without clarification.

The capability map should end with an action, not a colour-coded impression. For each weak essential criterion, decide whether the evidence exists, needs authorised preparation, needs independent confirmation, or represents experience not yet obtained. The first three may be resolved before the deadline. The fourth may justify an application only if the criterion is developable; otherwise it belongs in the longer plan from Chapter 14. The map is valuable because it tells the truth early enough to influence a decision.

## Reading the job description and person specification

Read the complete recruitment pack twice. On the first pass, understand the service. On the second, create an assessment map. Save the version and date because pages can be amended or removed after the closing date. Do not rely on an online summary copied into an alert. The detailed documents determine the duties, entry criteria and evidence expected.

Start with scope. Name the patient group, pathways, sites, procedures and interfaces for which the postholder will be responsible. Ask whether ‘full range’ refers to a defined service area or the whole specialty. Identify exclusions and referral arrangements. If the description moves between broad specialty language and a narrow clinic without explanation, seek clarification. An applicant can meet a well-defined specialised scope without reproducing every aspect of consultant training; an unclear scope makes both application and later governance unsafe.

Next examine autonomy and accountability. Which clinical decisions will the postholder make? Is there named consultant input, peer support or cross-cover? Who holds service-line accountability? Will the Specialist lead a team, supervise doctors, authorise pathways or chair governance? Phrases such as ‘work independently’ and ‘support the consultant’ can coexist, but the practical relationship must make sense. Independence within competence is compatible with collaboration. Accountability becomes

hazardous when the doctor is expected to carry a result without the authority, staffing or information needed to achieve it.

Map the working pattern. Look for sites, programmed activities or sessions, predictable and unpredictable emergency work, out-of-hours commitments, travel, administration, supporting activity and flexibility clauses. A sample timetable may be illustrative rather than agreed. Compare it with the narrative duties. If the role includes service improvement, supervision, appraisal responsibilities or teaching, locate the time assigned to those functions. An attractive leadership paragraph that has no place in the proposed week may represent aspiration rather than a deliverable job.

Study the essential and desirable criteria line by line. Essential means the employer expects the criterion to be satisfied for appointment, although its method of assessment may differ. Desirable criteria can distinguish candidates but should not be treated as invisible essentials after applications close. Record where each criterion will be assessed: application, reference, interview, presentation, occupational or pre-employment check. If the document does not state this, prepare evidence for the written application and interview while keeping within the form's instructions.

Qualifications require exact reading. The employment grade is not the same as the Specialist Register, so do not assume registration is mandatory unless the vacancy says so and the requirement is lawful and relevant. Equally, do not assume that years after qualification automatically satisfy the employer's entry wording. Check the live person specification, the applicable national template and any specialty-specific requirement. If a criterion appears internally inconsistent—for example, the advertisement welcomes SAS applicants while the form asks for registration not normally required for the grade—raise it promptly with recruitment and retain the response.

The national entry wording includes full GMC registration with a licence and at least twelve years' medical work after primary qualification, of which at least six years should be in a relevant specialty in Specialty Doctor or closed SAS grades; equivalent relevant experience from other grades, including overseas, is also accepted. Apply the live vacancy wording and prove dates rather than rounding them. [99][5]

Test each leadership statement for authority and resource. 'Lead development of the service' could mean designing and implementing a defined pathway with access to data and a reporting line. It could also mean being held responsible for vacancies and waiting lists without budgetary or managerial authority. Ask which decisions belong to the doctor, which require approval, who provides project and analytical support, and how

objectives will be agreed. The answer affects both willingness to apply and the examples to foreground.

Quality and governance need the same scrutiny. Identify expected meetings, incident-review work, audit or quality-improvement responsibilities, guideline ownership, complaints contribution and duty to raise concerns. Ask how data will be provided and who owns organisational risks. A Specialist doctor should participate actively in governance, but an employer cannot make every system failure an individual medical duty through a broad sentence. The post should sit in a defensible governance structure with escalation routes.

For education, distinguish bedside teaching, clinical supervision, educational supervision, assessment, faculty work and programme leadership. Each requires different preparation and evidence. If the post will supervise doctors in training, ask what recognition, training and time are expected under the local framework. If the role covers LEDs, students or other professionals, clarify reporting and escalation. A candidate's enthusiasm for teaching should not be used to create an unlimited unpaid function after appointment.

Check practical resources before interpreting the role as an advancement. Does it have appropriate workspace, administrative support, IT, access to data, continuing professional development and study leave, mentorship or peer connection? How is cover arranged for leave? Does the service expect cross-site travel within the proposed timetable? A senior title cannot compensate for a design that makes safe delivery improbable. These questions can be asked professionally and in stages; they need not all be posed as objections in the first telephone call.

Finally, identify the service problem beneath the paperwork. Review the organisation's published strategy, relevant quality information and any material supplied by the recruiting team. Ask the clinical contact what the successful candidate should have achieved at six and twelve months. Listen for alignment between that answer and the job description. A panel presentation often concerns service development. Understanding the real problem allows a candidate to propose a measured first step instead of promising a transformation without resources.

The vacancy analyser can be set out in ten rows: defined scope; clinical autonomy; boundaries and escalation; leadership authority; quality responsibilities; education; research and scholarship; working pattern; resources; and first-year outcomes. For every row record the source wording, your interpretation, a question requiring clarification, and one relevant evidence example. Add a final decision—apply now, seek

clarification, or do not apply—with reasons. This turns a promotional document into a professional decision.

## England source set

For an England post, begin with the current NHS Employers Specialist terms and conditions, model contract, generic capabilities framework, appointment guidance and person-specification materials. Then place the employer's live recruitment pack above them for vacancy-specific criteria. The terms establish the national employment architecture; the capability and appointment materials support role design and recruitment; the vacancy states what this employer is actually seeking. None should be replaced by recollection of a neighbouring trust's process. [99][101]

The Specialist role was introduced within the 2021 SAS contract reform. The national concordat supported the creation of appropriate Specialist roles and a consistent method for appointments. That history helps explain why vacancy numbers and designs differ between organisations. It does not create an individual entitlement to promotion after a certain number of years. Employers need to identify service need and establish posts; candidates then compete under the published process. If local practice seems inconsistent with national materials, a candidate or staff representative can raise the specific discrepancy without assuming the appointment outcome.

England also introduced an SAS Eligibility and Permanency Framework in 2026, with applications opening on a rolling basis from September 2026. It concerns eligible locally employed doctors whose duties and responsibilities are comparable with national SAS roles and provides a process for movement to an appropriate permanent national contract. It should be date-labelled and read in full by anyone relying on it. It is not the same as open competition for a newly advertised Specialist post, and it is not a generic Specialty Doctor-to-Specialist regrading policy. An LED may need the framework to establish the appropriate national contractual destination; an existing Specialty Doctor considering a Specialist vacancy still follows the vacancy and appointment process. [102]

This distinction matters when colleagues use 'transfer', 'conversion' and 'progression' interchangeably. Ask what is changing: employer, contract, grade, duties, or regulatory status. A doctor moving from a local contract to nationally recognised terms may gain permanency and contractual clarity without obtaining Specialist registration. Whether the appropriate SAS grade is Specialty Doctor, Specialist or a closed legacy grade depends on the framework's criteria and evidence, not on the doctor choosing the most senior label. Because the framework is new and operational detail may

evolve, check the live joint guidance and local implementation before acting.

Recruitment equality and organisational policy also apply. Follow the employer's instructions about reasonable adjustments, supporting statements, values evidence and declarations. If a candidate needs an adjustment, request it through the stated route early enough for the employer to arrange it. Do not dilute relevant evidence in an attempt to avoid discussing an adjustment. Selection should assess the stated requirements using an accessible process, while occupational-health questions and adjustments have their own appropriate timing and confidentiality.

Where an England pack is unclear, ask the named recruitment contact to identify the current version of the terms, person specification and proposed job plan. A trade union or professional adviser can help interpret contractual points. The aim is not to turn every application into a dispute. It is to ensure that the candidate knows which grade is offered, which standards apply and what they are being asked to accept.

## Northern Ireland source set

Northern Ireland has its own published SAS 2021 contract documentation. The Department of Health collection includes the Specialist terms and conditions, model contract, generic capabilities framework, concordat, notes on the person-specification template and a Northern Ireland template. These documents should be used directly for a Northern Ireland appointment rather than assuming that an England webpage is operative. The broad capability architecture is shared, but the contract, employer structures and current pay circulars belong to the jurisdiction. [5]

The Northern Ireland person-specification template explains how employers should identify capabilities that are key for the post and those required but not key. It gives examples of evidence and identifies several capabilities expected to be tested at interview because of the level of clinical responsibility and autonomy. It also recognises that some capability may be developed prospectively and then assessed through later appraisal. The candidate should examine how the employing trust has adapted the template, not submit a generic response to the national list. [100]

Omar's vacancy is in a defined generalist service. The phrase 'specialised area' therefore does not mean a narrow procedural subspecialty. The national framework expressly allows expertise in a specialised area within a specific specialty or a generalist service. Omar maps his evidence to the actual presentations, uncertainty and service interfaces described in the pack. He does not claim the breadth of an unrelated tertiary role, and he does

not apologise for generalist expertise. The question is whether he can manage the full range within the defined practice area at the required level.

Northern Ireland's concordat and capability materials assist services to establish roles, but they do not remove workforce constraints or local approval. A candidate may hear that a department supports a Specialist post but cannot yet advertise it. That is a workforce discussion, not a selection outcome. Preserve any agreed development plan, continue to make work visible through job planning and ask for realistic timescales, but do not write an application to an imaginary vacancy. When a post is published, start again from its final documents because scope and criteria may have changed during approval.

Pay and contractual details should be checked against the current Northern Ireland terms and pay circular at the point of offer. The model contract is useful for structure, but the actual written offer and statement of particulars need careful review. If prior experience is said to affect starting salary, ask the employer to explain the basis and provide the decision in writing. Do not assume that the England pay table or a colleague's outcome transfers automatically.

The same applies to work schedules, out-of-hours arrangements and job-planning mechanisms. The role may be clinically similar across the Irish Sea while contractual language and local process differ. Omar separates questions for the panel—about service and expected capability—from questions for medical staffing and his adviser about terms. This prevents an interview from becoming an improvised contract negotiation while ensuring that consequential matters are not forgotten after a verbal offer.

If the recruitment pack uses an obsolete label or appears to mix Specialist with Associate Specialist, seek written clarification. Associate Specialist is a closed legacy grade; Specialist is the newer national grade. Similar seniority in everyday speech does not make the contracts interchangeable. A candidate should know exactly which national terms, pay scale and job-planning provisions are proposed before accepting.

## Building the written application

The written application is an evidence map expressed in prose. Begin with the essential criteria, not the chronology of your career. Create a working table with one row per criterion and five columns: requirement; strongest example; supporting record or witness; result and learning; relevance to this post. Only then draft the form. This protects the application from becoming a long biography in which the panel has to search for answers.

Use a responsibility-action-result-learning-relevance sequence. Responsibility explains what you were accountable for and the setting. Action identifies your decisions and contribution. Result reports what changed, including uncertainty or incomplete outcomes. Learning shows reflection and adaptation. Relevance connects the example to the advertised role. The sequence is not a rigid acronym to recite in interview. It is a check that each example demonstrates more than attendance.

Priya's strongest improvement example concerns delayed follow-up of investigation results in a composite service. She did not 'single-handedly redesign the pathway'. Her application says that she identified a recurrent risk through governance review, agreed a project scope with the multidisciplinary team, analysed an authorised aggregate baseline, led a small test of a revised allocation process, and returned with follow-up data. The measured delay reduced during the test, but one site did not sustain the change. She explains what she learnt about ownership and monitoring and how she would establish the advertised post's governance work. The account is credible because its verbs match the records.

Omar initially writes: 'I have vast experience of managing complex patients independently.' He revises this into a defined example. He describes the service population, a difficult decision under uncertainty, the information available, how he involved the patient or family, when he sought specialty advice and how follow-up was arranged. He preserves confidentiality and does not submit patient records to recruitment. The example shows the judgement, boundaries and communication that 'autonomous' is meant to convey.

Select a spread of evidence. One clinical case can demonstrate judgement but not sustained service leadership. One audit can show analysis but not necessarily implementation. One positive reference cannot establish every criterion. Aim for complementary examples across clinical practice, team leadership, safety and improvement, education and evidence use. Where the form limits words, mention a second example briefly or reserve it for interview. Repetition wastes space and makes the portfolio appear narrower than it is.

State your role in collective work. Senior NHS achievements are almost always shared. Panels do not require a solitary hero; they need to understand the candidate's contribution. Use 'I' for your decisions and 'we' for the team's work. If the project had an executive sponsor, data analyst, nurse lead and patient partner, say so where relevant. Giving credit increases rather than reduces credibility. It also demonstrates the collaborative leadership expected of the grade.

Address every essential criterion explicitly. If one example covers two criteria, tailor the explanation to each or cross-reference only where the form permits. Do not make a panel infer a qualification, licence status or experience from the CV when the application asks for confirmation. Check dates and names across the employment history, supporting statement and declarations. An unexplained discrepancy may distract from a strong application and can delay checks.

For desirable criteria, show relevance rather than accumulating labels. A postgraduate qualification matters if it supports the role's practice, education or service development. A publication matters if it shows scholarship useful to the work. Committee membership matters if the candidate contributed to decisions and can describe an outcome. Prestige without connection uses words that should have been spent on evidence.

Handle gaps openly but proportionately. If formal educational-supervisor recognition is desirable and you are enrolled for the required development, say what you have already done, the current status and the expected completion date without presenting it as achieved. If an essential criterion is missing, seek clarification before applying; do not disguise it. A shortlisting panel may reject the application, and a misleading assertion creates a more serious professional issue than honest non-appointment.

Avoid confidential detail. Recruitment evidence should be anonymised and authorised for use. Describe the clinical or governance problem at the level needed to show judgement. Do not attach patient records, incident-system screenshots or confidential investigation papers unless the employer's process expressly requires an appropriately handled document and you have confirmed the lawful route. A panel normally needs a truthful account and suitable organisational evidence, not access to the underlying patient file.

The personal statement should answer three questions: why this role, why this service, and what evidence shows readiness. Replace generic admiration for the organisation with a concrete connection to its published need. Explain the specialised contribution you can make, the first issues you would need to understand and the boundaries of what can be promised before appointment. Confidence is compatible with conditional language where resources and baseline data are not yet known.

Before submission, conduct a cold-reader test. Give the person specification and draft to a trusted colleague who did not work on the examples. Ask them to underline where each essential criterion is evidenced and to state what they think your contribution was. If they cannot find it, the panel may not find it. Correct ambiguity rather than adding adjectives. Then

proof dates, qualifications, registration, referee details and declarations against source records.

The final criterion matrix should remain after submission. Add the exact paragraph or example used, likely interview question and one reserve example. This becomes the interview plan. Priya's matrix shows strong evidence across most domains but only a modest research claim. She does not manufacture research leadership; she explains critical appraisal and implementation of evidence relevant to the role. Omar's map shows sustained clinical capability but less formal service evaluation, so he prepares a careful account of what he has contributed and what support he would seek in the new post.

## References and pre interview due diligence

Choose referees who can comment on the work most relevant to the post and who meet the employer's instructions. Senior title alone is insufficient if the referee has little direct knowledge. Speak to each proposed referee before submitting, confirm contact details, provide the current job description and remind them of the examples they directly observed. Do not script praise or ask someone to certify work they did not see. A specific, accurate reference is more valuable than a prestigious but generic endorsement.

If the employer requests the current or most recent line manager and you have a reason for proposing another referee, follow the form's route and explain it appropriately. Do not omit a required employment relationship silently. Concerns about confidentiality, conflict or an ongoing process should be discussed with recruitment or an adviser. The purpose is to meet the process while ensuring that information is accurate and relevant.

Pre-interview due diligence is an active professional conversation. Arrange contact with the named clinical lead and, where offered, a visit or virtual discussion. Ask what led to creation of the post, how its scope was determined, what the team expects in the first year, which resources are agreed and what remains under development. Listen for differences between the job description and operational reality. Record factual answers for your own preparation, but do not treat an informal conversation as a contractual promise.

Ask how clinical autonomy works at difficult boundaries. Which cases remain within the Specialist's scope? What advice is available outside normal hours? Who covers absence? What happens when demand exceeds capacity? How are disagreements escalated? These questions demonstrate mature judgement when asked constructively. A candidate should be wary of a role described as fully autonomous only when the service wants

someone to absorb risk, but closely controlled when the doctor needs authority to improve it.

Examine the proposed job plan. Identify direct clinical care, supporting professional activity, leadership, education, travel and on-call. Ask which elements are fixed, what can be negotiated after appointment and how the initial plan will be reviewed. If significant work is expected but unscheduled, raise it. The first job plan should make the role deliverable, not rely on the new postholder donating evenings to justify the grade.

Clarify the team and infrastructure. Ask about vacancies, administrative support, data access, supervision responsibilities, relationships with consultants and other Specialists, and current improvement priorities. Where the post crosses sites or organisations, ask how accountability and information flow are arranged. A candidate cannot calculate every future difficulty, but can identify whether the organisation understands the design it is recruiting into.

## Interview and presentation

Prepare by capability and criterion, not by guessing a list of questions. Build an interview bank covering clinical judgement under uncertainty, recognising limits, multidisciplinary conflict, patient-centred communication, raising concerns, quality improvement, leadership, education, use of evidence, equality and values, and service development. For each area, prepare a primary example, a shorter reserve and the lesson that will alter your future practice. The examples should come from real professional work presented without identifying details.

A strong answer makes the decision visible. Set the context briefly, state your responsibility, identify the competing considerations, explain the action and result, then reflect. Do not spend most of the answer describing the organisation. If the outcome was imperfect, say what remained unresolved and what you changed. Panels often learn more from a candidate who can analyse a limited result than from one whose every story ends in triumph.

Clinical scenarios test method as well as knowledge. Establish immediate safety, obtain relevant information, involve the patient and team, recognise limits, escalate appropriately, document and arrange follow-up. The exact clinical response depends on the specialty and scenario. The seniority signal is not maximal certainty; it is structured judgement that can operate under uncertainty while preserving accountability. If information is missing, state what you need rather than inventing it.

Governance scenarios need a similar sequence. Describe how you would contain immediate risk, preserve facts, use the relevant reporting and escalation route, support those affected, and contribute to learning without prejudging a formal investigation. Distinguish individual action from system responsibility. An answer that promises to ‘deal with’ a colleague alone may overlook process, fairness and patient safety. An answer that sends every issue upwards without taking any action may not demonstrate Specialist leadership.

For leadership questions, avoid title-based claims. Explain a situation in which you had to align people who did not report to you, challenge a proposed course or sustain a change after initial agreement. Identify power and constraints. Say how you sought dissent, what you decided and how the decision was communicated. If the project depended on senior approval, be clear. Influence within governance is not diminished by acknowledging where formal authority sat.

Education questions should move beyond enjoyment of teaching. Describe how a learning need was identified, what you designed, how you adapted for the learner or team, what feedback was obtained and what changed. If the role involves supervision, be ready to discuss boundaries, documentation, learner safety and escalation of concern. Do not claim formal educator status from informal mentoring. Explain current recognition and development accurately.

A presentation is a test of prioritisation. Confirm the title, duration, audience, equipment and whether questions are included. Define the service problem before proposing a solution. Use available evidence, state assumptions and distinguish actions the postholder can initiate from decisions requiring organisational approval. A practical structure is: problem and why it matters; what must be understood in the first ninety days; one or two feasible tests; measures; stakeholders and risks; and what a twelve-month review would examine.

Do not promise results that depend on resources you have not seen. ‘I will eliminate the backlog in six months’ may sound energetic but reveals weak due diligence. A better answer identifies baseline demand and capacity, patient-risk stratification, process mapping, staff involvement, a testable change and balancing measures. Explain what would cause you to stop or modify the intervention. This shows that improvement is governed work, not a slogan.

Prepare questions for the panel that follow from the role. Ask about first-year priorities, governance, authority, job-plan review, team development and support. Avoid asking only what is already clear in the pack.

Contractual detail can be confirmed with medical staffing after a conditional offer, but a material ambiguity about role scope should be resolved before you decide whether appointment is acceptable.

Priya and Omar now diverge. At Priya's interview, she uses a concise range of evidence. She explains autonomous clinical work without denying the value of consultation, shows a quality project including its partial failure, and presents a measured first-year plan. Omar relies mainly on length of service and repeated assurances that everyone trusts him. His clinical answers are sound, but the panel cannot identify his personal contribution to governance or how he would establish the new service responsibilities. Similar years have produced different assessable evidence.

This comparison is not a moral judgement. Omar may be equally capable in daily practice. The appointment process can assess only what is relevantly demonstrated through the permitted methods. His next step is not another decade of service. It is to define scope, obtain proportionate evidence, create opportunities to demonstrate missing domains and practise explaining decisions. The result illustrates why evidence maintenance in Chapters 12 and 14 is career infrastructure rather than self-promotion.

After interview, write down the questions, your answers and any new information about the role. If unsuccessful, request feedback under the employer's process. Separate criterion-based feedback from vague commentary, compare it with your evidence map and decide what action is justified. A single panel decision is not an authoritative verdict on an entire career. Equally, dismissing every disappointment as predetermined prevents learning. Look for a specific gap, communication problem or mismatch and seek advice if the process itself appears materially flawed.

## Offer and first Specialist job plan

A verbal indication is welcome but incomplete. Wait for the conditional written offer and complete the required checks. Confirm the employer, grade, national contract, salary basis, hours or programmed activities, base, on-call, start date, probation if any, leave, notice and pre-employment conditions. Compare these with the advertisement and discussion. Where wording differs, ask for clarification before resigning from an existing post or treating the appointment as final.

Salary placement should be explained under the applicable national terms and current pay arrangements. Provide requested evidence of reckonable experience, but do not infer the outcome from another doctor's appointment. Ask for the calculation or decision in writing and obtain contractual advice if

necessary. Pay is important, yet the value of the role also depends on job-plan realism, authority, support and long-term sustainability.

Use the proposed job plan as an operating agreement. List the clinical duties, leadership, governance, education, administration, continuing professional development, on-call and travel that the role actually requires. Attach realistic outputs and dependencies to major objectives. If the service expects the new Specialist to develop a pathway, identify data, managerial support, stakeholder authority and time. A title does not create these resources.

Agree boundaries and escalation early. Record the defined area of autonomous practice, access to advice, cross-cover and how new duties will be introduced. This is particularly important when appointment recognises some existing capability but the job adds unfamiliar responsibilities. Development after appointment should be planned, supervised where needed and reviewed. The national person-specification approach allows some capabilities to be developed prospectively; this must become a real plan rather than an assumption that the postholder will learn invisibly while carrying full responsibility. [100]

Set a first-year evidence plan. In the first month, confirm scope, governance contacts and baseline priorities. By three months, review whether the job plan reflects actual work and whether agreed resources are available. By six months, examine early objectives, development and team relationships. By twelve months, evaluate results and revise the plan. These are practical review points, not universal contractual deadlines. Use the formal job-planning and appraisal mechanisms applicable to the contract.

The offer checklist therefore asks: Is this definitely the Specialist grade under the correct national terms? Is the scope defined? Are authority and accountability aligned? Is all expected work scheduled? Are support, cover and data identified? Is salary placement explained? Are prospectively developed capabilities named with support and review? Is there a safe route to raise a mismatch? Does the post still serve the destination chosen in Chapter 14?

Priya accepts only after these questions are answered. Her appointment does not place her on the Specialist Register and she does not describe it that way. It does establish a new employment role with a defined scope, national terms and explicit responsibilities. Omar uses his feedback to rebuild the evidence record and seek opportunities linked to the next suitable vacancy. Neither outcome is automatic reward or permanent judgement. Both are decisions that can be understood and acted upon.

Before any later application, refresh every source. England’s 2026 Eligibility and Permanency Framework, national pay arrangements and local recruitment systems can change. Northern Ireland’s terms and pay circulars can also change. Keep the source date beside the decision. The enduring method is to identify the destination, read the live documents, map evidence to criteria, test the role, and accept only after the work and contract are intelligible.

Chapter 18

# Specialist registration through the Portfolio Pathway

## What the Portfolio Pathway is

Priya's appointment decision in Chapter 17 concerned an NHS employment post. This chapter concerns a regulatory destination. The GMC's Portfolio Pathway is a route to the Specialist Register or GP Register for doctors who have not completed the corresponding approved UK training programme but can demonstrate the required knowledge, skills and experience through evidence. It replaced the familiar CESR and CEGPR terminology in 2023. Older records and colleagues may still use CESR, so the former term is worth recognising for searches; the live application must use the current route and current guidance. [8]

Specialist registration and the Specialist employment grade are separate. A doctor may hold a Specialist-grade NHS post without being on the Specialist Register if the post's lawful requirements permit it. A doctor may enter the Specialist Register and remain in a Specialty Doctor, academic, independent or other role. Registration can widen eligibility for posts that require Specialist Register entry, including many consultant appointments, but it neither creates a vacancy nor guarantees selection. The evidence standard and decision-maker for the Portfolio Pathway are regulatory, not the employing department's promotion arrangements.

Nor is the pathway an appraisal with more attachments. Annual appraisal reviews the whole scope of current practice and professional development. A Portfolio Pathway application is assessed against the high-level learning outcomes of the relevant approved curriculum, using the current specialty-specific guidance. An appraisal summary may help explain activity, but it cannot automatically demonstrate a clinical outcome that the appraiser did not observe or assess. Revalidation confirms continuation of the licence under its own process; it does not certify equivalence to a specialty curriculum.

The route is evidence-led but not merely documentary. Documents have to establish current capability across the required outcomes. An applicant with thousands of pages can have serious gaps. Another applicant may need fewer, better-organised records where each item is primary, recent, relevant and properly verified. The goal is not to show that a long career was busy. It

is to allow evaluators to reach a defensible judgement about the standard required for specialist registration in the chosen specialty.

Portfolio Pathway is therefore not a shortened training programme and the applicant does not receive a national training number by opening an application. The doctor may use structured development, workplace assessment and supervised experience, but responsibility for planning the evidence remains different from progression through an approved programme. Local support can reproduce some educational opportunities; it cannot award a CCT or alter the GMC's standard. This makes early realism essential: years of service may contain substantial relevant capability while leaving outcomes that the job never required.

Think of the application as a structured argument. The curriculum states the outcomes. The specialty-specific guidance explains expected evidence, recency, organisation and referees. Primary records show practice and achievement. Cross-references explain how each record contributes. Referees provide structured reports based on direct knowledge. Verification and authentication address provenance. The GMC controls the process and makes the final registration decision, informed by evaluation from the relevant Royal College, faculty or associate. [103]

This chapter does not offer a universal evidence list. Specialties differ, curricula change and the GMC tells applicants to work from the website version of the specialty-specific guidance because it is the most current. A safe method must therefore survive an update: choose the correct route, capture the live sources and dates, construct the map, plan genuine experience for gaps, prepare evidence to the specified controls and audit the whole submission before paying and closing it. [88]

The first question is consequently not 'How quickly can I upload my portfolio?' It is 'Which specialist destination am I trying to reach, and what does the live GMC framework require today?' A doctor who can answer that has started the pathway. A doctor who begins with folders alone may spend months improving evidence that does not address the correct standard.

## Eligibility and choosing the correct application

For a specialist-registration Portfolio Pathway application, the current GMC eligibility page says that the applicant must have either a specialist qualification in the specialty being applied for or at least six months' continuous specialist training in that specialty. The applicant must provide evidence of eligibility and demonstrate the high-level learning outcomes in the CCT curriculum through robust and objective documentary evidence. Full registration with a licence to practise is required to apply and to be

granted specialist or GP registration. These are threshold matters, not evidence that the application will succeed. [104]

Use the GMC's application route finder before deciding that Portfolio Pathway is correct. A doctor who completed an approved UK programme may need the CCT route. A doctor with a qualification on the current recognised specialist qualification list may have an RSQ route. Acquired rights or other circumstances can produce different applications. Choosing a familiar label from colleagues can waste fees and time. Where overseas qualifications, mixed training histories or a non-CCT specialty create doubt, contact the GMC specialist applications team before submission and retain the written clarification.

The chosen specialty matters as much as the route. For a CCT specialty, the application must demonstrate the knowledge, skills and experience required by its curriculum. For a non-CCT specialty, the GMC says the applicant must show the standard required of a consultant in any of the UK health services and advises contacting the GMC before applying so it can confirm that the specialty is appropriate. 'My current job title contains the specialty name' is not enough to resolve a boundary between related specialties or a subspecialty. [105]

Priya is a composite senior Specialty Doctor whose work includes general internal medicine and a defined area of older-person care. She has considered both competitive Specialist posts and specialist registration. Her first mistake is to ask colleagues whether she should 'do CESR in medicine'. That phrase leaves at least four uncertainties: the current route name, intended specialty, curriculum, and whether a dual specialty outcome is sought. She replaces it with a written destination statement naming the register entry she wants and the roles for which it would be relevant.

She then records her eligibility evidence. Her overseas postgraduate training included continuous specialist training, but its programme title does not match the current UK specialty exactly. She does not translate the title informally or assume that a certificate proves the required six months. She gathers the official training record and programme description and asks the GMC what route and specialty are appropriate. This early enquiry is not an application for advance approval; it prevents the evidence plan being built on an untested assumption.

Timing the start also requires judgement. The GMC currently allows up to twenty-four months for building an application after it is started, but the active process contains later, much shorter response periods. A generous outer window is not a reason to open the application before the curriculum map, source versions, verifier plan and major experience gaps have been

examined. Starting too early can expose the applicant to curriculum change, expiring evidence or avoidable pressure. Waiting forever can allow recent evidence and accessible verifiers to disappear. [8]

Use a readiness gate before opening the application. Confirm the route and specialty; download or record the curriculum and live specialty-specific guidance version; identify the required high-level outcomes; check recency rules; locate sufficient current primary evidence across the breadth; identify major gaps; confirm feasible access to development; identify potential referees and verifiers; estimate cost and protected time; and consider whether an impending move will disrupt access. 'Mostly yes' is not the same as complete readiness, but the gate reveals whether starting is sensible.

Where an applicant is planning a move between employers or nations, the regulator and standard remain UK-wide, while evidence access and organisational support change. The new employer does not inherit the ability to verify another institution's records. Obtain authorised records and discuss verification before leaving. Equally, do not carry confidential records into a personal archive merely because a future application is possible. Chapter 12's departure plan and the GMC's precise verification rules should guide preparation.

The decision to pursue the pathway should also reflect destination. If the doctor wants a defined Specialist-grade post that does not require Specialist Register entry, competitive appointment may be the more immediate route. If the goal requires register entry, the Portfolio Pathway may be appropriate. Some doctors will pursue both on different timetables. Neither is inherently superior. A useful plan names the benefit sought, evidence burden, opportunity cost and alternative, rather than treating registration as compulsory proof of professional worth.

## Curriculum and specialty specific guidance

The curriculum and specialty-specific guidance—usually abbreviated to SSG—are the application's organising sources. The application form provides headings, but the GMC states that the SSG gives much more detail about the evidence expected. Its introductory sections explain relevant evidence types, cross-referencing, sufficiency, organisation, referee requirements and recency. Work from the live website version, not an old copy received from a colleague. Preserve a dated copy or audit note for your planning, while checking the live page regularly for changes. [88]

Begin with the high-level learning outcomes. Rewrite each as a question an evaluator must be able to answer from the submitted evidence. Then identify component requirements in the curriculum and SSG. Do not reduce

the map to procedures. Modern curricula include clinical capability alongside professional behaviour, communication, patient safety, quality improvement, leadership, education and scholarship. A doctor may have remarkable depth in a service niche but still need evidence across broader outcomes.

The SSG controls specificity. It may require particular forms of workplace evidence, numbers or spreads of activity, evidence from specified recent periods, named assessments, log formats or a particular referee profile. Those details differ between specialties and can change. This book deliberately does not invent one set of universal numbers. The correct number of referees, acceptable recency and expected evidence must be copied from the live SSG into the applicant's control sheet and checked again before submission.

Curriculum mapping is not the same as imitating a trainee's portfolio. An applicant may have developed capability through service work, overseas training, supervised practice, formal education and later senior responsibility. The evaluator still needs evidence of the required outcomes. The task is to demonstrate the standard through legitimate records, not to recreate an electronic training record retrospectively or backdate assessments. Where a trainee-style tool is suggested by the SSG, use it prospectively and honestly with a suitable assessor.

Curriculum changes introduce version risk. The GMC explains that some specialties may dual run a new and previous curriculum after a significant change, and the relevant SSG states whether this applies. Dual running is not permission to combine whichever parts of two curricula are easiest. Select the permitted curriculum under the current instructions, record the choice and build a coherent application against it. Check implementation dates and update notices, particularly if the application will span many months. [88]

If a curriculum is due to change, ask the GMC how the transition affects the intended application. Do not infer an entitlement from a draft College consultation or a friend's older submission. A new curriculum may reorganise outcomes, change evidence expectations or create a dual-running period. The application should include a version-control line: specialty, curriculum title and version, SSG title and date checked, GMC clarification if any, and next review date.

Royal College and faculty materials can help interpret the curriculum and plan development, but GMC guidance remains controlling for the application. A College course may teach an assessment method; a specialty society may offer valuable mentoring; a successful former applicant may explain practical organisation. None can promise acceptance or waive a

current requirement. When advice conflicts, return to the live GMC source and obtain clarification from the specialist applications team.

Distinguish an outcome from its suggested evidence. The outcome states what must be demonstrated; an evidence example illustrates one way it may be shown. If the SSG allows several forms, choose the one that most directly records the applicant's real practice. Do not force a weak document into the map simply because its label resembles a curriculum heading. Conversely, do not reject strong primary evidence solely because another applicant used a different tool. The SSG's wording and the evidential proposition govern the choice.

Create a curriculum dictionary for terms that could be misunderstood. Record how the live curriculum uses words such as manage, supervise, lead, contribute, competent and independent. Compare these with the applicant's work and local terminology. A department may call participation 'leadership', or call supported practice 'independent', without intending the curriculum meaning. Defining the claim before selecting evidence reduces accidental exaggeration and helps supervisors arrange development at the correct level.

Priya initially maps all of her evidence to a broad list from a course attended two years earlier. The list describes knowledge, procedures, teaching and audit, but does not show the current high-level outcomes or updated recency rules. She rebuilds the map from the live curriculum and SSG. Some documents remain useful. Others move to a background archive because they no longer help the evaluator answer the required question.

She also learns that breadth is not achieved by attaching one example to every row. A single acute case may touch several outcomes, but it cannot demonstrate sustained practice across settings. She identifies the range described by the curriculum and compares it with her actual work. For areas no longer in her current job, she asks whether older evidence plus current maintenance can meet the SSG or whether supervised experience is needed. The SSG, not optimism, governs that judgement.

Create a source-change log. Each time the online SSG or curriculum is checked, record the date, whether the version or content changed, and the consequence for the evidence map. This need not become an elaborate audit. Its purpose is to prevent two applicants working together from unknowingly using different instructions and to show why an evidence plan was revised. Before final submission, conduct a clean comparison with the live sources rather than assuming that no notification means no change.

## Build the evidence map first

An evidence map is the application's working architecture. It should exist before the applicant starts collecting more documents. Use one row for each required high-level outcome and meaningful component. Suggested columns are: exact requirement; SSG instruction; primary evidence; date and setting; personal contribution; verifier; cross-reference; gap; planned action; and readiness status. Add a source version at the top. The map belongs in an approved working location and should not itself contain patient-identifying detail.

Start with claims, not files. For each requirement, write a narrow statement of what your practice demonstrates. Then identify the strongest primary record. A workplace assessment, log, case-based discussion, approved audit, teaching evaluation or governance output may have value depending on the SSG. A CV, reflection or appraisal summary usually provides explanation rather than direct proof of every underlying capability. The evidence register in Chapter 12 can supply candidate items, but the curriculum map decides which are relevant.

Separate availability from sufficiency. A green cell should mean that the required outcome is supported by appropriately recent, robust evidence under the SSG—not simply that a PDF exists. Amber may mean evidence exists but needs preparation, verification or complementary breadth. Red may mean the experience or evidence is absent. Grey may identify a requirement needing interpretation. Each status requires an action and owner. A colourful spreadsheet without those decisions is merely reassurance.

Map primary evidence before secondary explanation. Priya's appraisal summary says that she led improvement. Her primary evidence includes an agreed remit, baseline analysis, meeting record showing her contribution, authorised report of the tested change and follow-up data. The summary may connect these records and show reflection. It cannot replace them. Where no primary record survives, a properly scoped retrospective confirmation may have limited value if allowed, but it should never be made to look contemporaneous.

Use cross-references to reduce duplication. The GMC advises applicants not to submit the same evidence more than once and to cross-reference it in summaries. Give each item a stable identifier and a title that follows the current naming convention. If a quality project supports clinical governance and leadership, upload the evidence once and explain its different relevance in the appropriate mapped sections. Duplicating the file increases volume without increasing proof and can create inconsistent versions. [8]

Make contribution explicit in team evidence. An organisational guideline proves that a guideline exists. It does not prove that Priya designed it. Minutes may show attendance but not leadership. Pair the approved product with records or confirmation of the candidate's role, and use accurate verbs. 'Reviewed the evidence and drafted section three' is stronger than an unsupported claim to have 'led the guideline'. Evaluators need to know what the applicant did, not merely what the service achieved.

Every evidence item should have a four-line annotation: what it is; when and where the activity occurred; what it demonstrates; and where the applicant's contribution can be seen. Add any limitation. This is not an invitation to argue around weak evidence. A clear annotation saves the evaluator from guessing and helps the applicant recognise when the document cannot support the proposed claim.

Build gap plans around genuine experience. If Priya lacks current evidence of managing a required presentation, the answer is not to write a longer reflection on old practice. She may need an agreed placement, supervised activity, workplace assessment and evidence of maintenance. If the gap concerns education, she may need to plan, deliver, receive feedback and improve a programme. If it concerns research capability, critical appraisal and implementation evidence may be relevant depending on the curriculum; a last-minute honorary title will not create the required work.

The job plan is a development instrument. Translate gaps into agreed activities, time, supervision, access to cases or data, assessments and review dates. Distinguish what the doctor can do from what the employer must provide. An objective such as 'complete Portfolio Pathway' is usually too broad and places every dependency on the applicant. Better objectives specify an outcome, an opportunity and evidence: participate in a defined clinic with named supervision, complete agreed assessments across a specified range, and review progress at a stated date.

Prioritise dependencies. Verification from a former institution may take months. A required workplace opportunity may depend on rota redesign. Feedback may require an approved collection process. Authentication and translation can involve cost and hard copies. Deal with these before polishing low-risk reflections. A dependency map should identify the person, request date, response, alternative and point at which the plan becomes unviable.

Run a monthly evidence conference with yourself or a mentor. Review one curriculum domain, examine the primary evidence and ask what a sceptical evaluator could reasonably conclude. Do not ask only whether the applicant feels competent. Ask whether the evidence is current, covers the

right breadth, shows personal contribution and meets control requirements. Record decisions and retire weak items. A smaller register of purposeful evidence is easier to maintain than an expanding digital attic.

Before submission, reverse the map. Select each uploaded item and ask which requirement would become unsupported if it were removed. If the answer is none, the item may be unnecessary. Then select each requirement and trace it to readable evidence and a suitable explanation. This two-way test exposes both clutter and gaps. It also identifies broken links, mismatched titles and evidence cited in a summary but absent from the application.

## Clinical breadth depth and recency

Specialist evidence must demonstrate more than longevity. Breadth concerns the range of practice required by the curriculum and SSG. Depth concerns the level of judgement, complexity and responsibility. Recency concerns whether the evidence supports current capability. These dimensions interact. A current log of narrow routine work cannot prove historical breadth remains maintained. A decade-old assessment of complex practice may be impressive but weak evidence of current performance unless supported as the SSG permits.

The GMC's general SSG page states that evidence should be recent in accordance with the specialty's guidance. Evidence outside that period is unlikely to carry weight unless accompanied by current evidence demonstrating maintenance of competence. Small amounts of older evidence may help if highly relevant and primary, within a body containing recent robust primary evidence. Older secondary evidence adds very little. Exact time periods belong to the live SSG. [88]

Construct a clinical coverage matrix. Rows represent the required presentations, settings, procedures or capabilities; columns record current exposure, responsibility, evidence type, outcome or assessment, date and gap action. Do not insert patient identifiers. Use aggregate information or authorised, anonymised documents. Where the curriculum requires emergency, inpatient, outpatient, community or procedural experience, show the actual spread rather than describing the employing service as 'comprehensive'.

Depth is visible in decisions. A log number proves volume only to the extent that the log itself is valid. Add evidence that shows assessment of complexity, formulation, management, uncertainty, consent, communication, review and escalation. Workplace assessments can be useful when conducted properly. Case-based discussion may show

reasoning. Outcome review or personal audit may show performance over time. The precise combination must follow the SSG rather than a universal recipe.

Describe independence with boundaries. Priya manages complex presentations without routine direct supervision, but seeks advice for defined subspecialty questions and escalates organisational constraints. Her evidence explains the governance framework. The ability to recognise limits is part of specialist judgement. Claims that she has 'worked entirely independently for years' are less persuasive because they conceal the system, scope and occasions when collaboration was necessary.

Old evidence needs a maintenance question. If Priya performed a required procedure regularly eight years ago but has not done it recently, a historical log cannot establish current competence. Depending on the curriculum and role, she may need supervised updating and current assessment, or the specialty may permit another form of evidence. She should not perform a procedure merely to create a number without proper authorisation, training and patient need. Application pressure never displaces clinical governance.

Service configuration can create hidden gaps. A doctor in a highly specialised unit may have great depth but limited general exposure. A generalist may manage wide presentations but lack the tertiary or procedural evidence required by the chosen specialty. Neither career is deficient in itself. The mismatch exists between current work and the selected regulatory destination. The gap plan may require a second setting, formal placement or reconsideration of specialty.

Use negative as well as positive outcomes responsibly. Evidence of complication review, incident learning or an uncertain diagnosis can demonstrate reflective, safe practice if anonymised and permitted. It should not become a defensive case narrative or disclose confidential investigation content. Explain what was known, what was decided, how review occurred and what changed. Evaluators need evidence of practice and learning, not a portfolio curated to suggest that every case was straightforward.

Clinical evidence should connect to patient-centred practice. Outcomes include communication, shared decisions, equality, safeguarding and continuity, not only technical intervention. Select evidence that shows adaptation to need and safe coordination where the curriculum requires it. Patient feedback may contribute but cannot prove every clinical skill. A balance of sources allows different aspects of practice to be assessed.

Sample the ordinary as well as the exceptional. A dramatic case can reveal reasoning under pressure, but specialist practice is also visible in

consistent review, prioritisation and follow-up across a workload. An authorised aggregate audit, a series of appropriately assessed encounters or a log linked to selected discussions may demonstrate consistency more convincingly than repeated retrospective accounts of memorable cases. Follow the SSG on format and amount; the principle is to let evaluators see both range and sustained standard.

Where activity data are used, explain denominator and context. A figure for procedures, clinics or admissions is not self-interpreting. State the period, working pattern, case mix, personal role and any material gap. Do not compare raw numbers with a full-time trainee or another service without understanding exposure. The objective is evidence of curriculum capability, not competitive volume. If the applicant worked less than full time or had an authorised absence, present the pattern accurately and concentrate on evidence quality.

Maintain a recency dashboard with the evidence date, SSG window, expiry risk and maintenance action. Review it when the application timetable changes. Do not treat evidence as expiring at midnight without reading the SSG; recency is assessed within the specified framework and overall evidence. The dashboard is a planning aid. Its purpose is to prompt current practice and evidence, not to manufacture activity before an arbitrary date.

## Governance quality leadership and education

Applicants often find the non-clinical outcomes harder because their contribution was real but poorly recorded. Routine clinical work generates notes and activity data. Leadership, teaching and improvement may leave only meetings, emails and collective products. Reconstructing the evidence later is difficult and can tempt overstatement. Plan these domains as work with objectives, authority, measures and outputs, then preserve appropriate evidence contemporaneously.

Quality improvement needs a complete arc: identify the problem, understand the baseline, involve stakeholders, test or implement change, evaluate effect and decide what follows. Attendance at an audit meeting is weak evidence of leading improvement. An audit with no response demonstrates measurement but not necessarily change. A project whose favourable graph stops immediately after launch may lack sustainability. Show your contribution, the team’s contribution, balancing measures and any result that did not support the original assumption.

Governance evidence can include appropriately authorised reports, contributions to guideline development, review of incidents or complaints,

risk work and implementation of recommendations. The exact items must meet the SSG and confidentiality rules. Do not upload entire incident files or patient-level exports because they appear official. Seek an approved, anonymised summary or a document specifically prepared for the application. Preserve the distinction between organisational findings and personal reflection.

Leadership evidence should show decisions and relationships, not office. A title establishes role but not capability. Describe how Priya defined a problem, listened to disagreement, used evidence, clarified authority, made or influenced a decision, and reviewed the result. Where a senior manager approved resources, say so. Where Priya chaired but did not own implementation, say so. Accurate boundaries demonstrate mature leadership and make the evidence verifiable.

Repeated small leadership can be more persuasive than one ceremonial appointment. Coordinating complex care, supporting team decisions, raising a safety concern, implementing a guideline and improving handover can show sustained capability when appropriately evidenced. Do not label every ordinary interaction leadership; select work in which judgement, influence or accountability is genuinely visible. Link it to the curriculum outcome and explain development across time.

Education should distinguish need, design, delivery, feedback, assessment and improvement. A teaching timetable and attendance certificate prove activity. Add an explanation of learning objectives, materials or observation where permitted, aggregated learner feedback, changes made and evidence of effect. If claiming supervision, establish the role, learner group, recognition and boundaries. Informal support is valuable but should not be renamed formal educational supervision.

Feedback from learners and colleagues needs provenance and proportion. A few thank-you emails cannot establish teaching effectiveness across years. A structured, authorised collection may be more useful. Negative feedback does not automatically weaken an application if the applicant analyses it and demonstrates response. Select a balanced record that shows how teaching changed. Do not disclose identifiable comments from learners or colleagues where the GMC requires their details to be removed.

Scholarship connects evidence to practice. Depending on the curriculum, useful evidence may include critical appraisal, guideline work, research involvement, publication, presentation or dissemination. Authorship alone does not prove every research capability. If the applicant recruited participants under another investigator, state the role. If a literature review informed a local change, show the method, governance and result. Do not

invent a research project to fill a box where the curriculum permits other evidence of scholarly practice.

Use a contribution-and-outcome sheet for every major project. Record the agreed problem, governance approval, team, your role, actions, decisions, measures, result, limitations, learning, evidence identifiers and verifier. This single record helps separate personal contribution from collective outcome. It also reveals whether the project offers primary evidence or only a reflective story.

Priya's portfolio contains certificates from leadership and teaching courses, appraisal reflections and letters praising her commitment. Her map shows that these are mostly secondary. Over the next year she obtains agreed responsibility for a defined improvement project, arranges observation of teaching, evaluates a revised programme and documents a difficult cross-team decision. The purpose is not portfolio theatre. The service work was needed; designing it well also creates legitimate evidence.

Protected time matters. If an employer supports the application, convert support into a written development plan, job-plan activity where appropriate, access to data or placements, named supervision and review. A promise that 'we will help' is difficult to implement. The doctor should also be realistic: the Portfolio Pathway remains an individual application, and organisational support does not guarantee the GMC outcome. The plan should improve practice even if the eventual destination changes.

For each non-clinical outcome, use a triangulation test. One item should establish the role or responsibility, another should demonstrate the work or decision, and a third should show feedback, result or learning where the SSG supports that combination. Triangulation does not mean multiplying documents mechanically. Its value is to prevent a role description being mistaken for delivery and a self-authored reflection being treated as independent proof. Cross-reference rather than duplicate the same item across domains.

## Anonymisation verification authentication and translation

Evidence control must be designed at the beginning. Anonymisation protects patients, colleagues and others. Verification confirms that training and experience records are true and accurate within the verifier's institution. Authentication certifies specified qualifications or registrations as genuine copies. Translation provides the required English version of non-English documents. These processes answer different questions. A solicitor who authenticates a certificate does not become able to verify clinical work; a

medical supervisor who verifies work does not automatically authenticate an overseas qualification.

The GMC instructs applicants to check every page for patient or sensitive data and to redact it before submission. It does not undertake anonymisation for the applicant. Identified personal information can lead to deletion and resubmission, exclusion at evaluation or failure of the application; the guidance also describes possible professional consequences. Redaction must be permanent. Drawing a black box over selectable text is unsafe. Check hidden spreadsheet material, embedded files, links, QR codes, filenames, headers, footers and document properties as well as visible paragraphs. [106]

The current anonymisation page lists patient names, addresses, contact details, NHS and other unique identifiers, document links or codes and patient photographs among material requiring removal. It also covers relatives and members of the public, and specifies colleague details requiring redaction in assessments, references or complaints. The page contains nuance about colleague names in other evidence, so use the live list rather than deleting every professional name mechanically. Preserve enough context for the evidence to remain intelligible without exposing protected information.

Create a redaction workflow. Work from an authorised copy, not the clinical source record. Identify the application purpose and minimum necessary content. Apply permanent redaction using an approved method. Flatten or export as required, then attempt to copy, search and reveal the removed text. Inspect every page at high magnification. Have a second trained person check where permitted. Store the submission copy separately and retain the unredacted source only in its authorised system under the applicable policy.

Verification operates by institution. The GMC says that most evidence relating to training and experience needs verification by someone in a medical supervisory position who works at the hospital where the training or experience occurred, can confirm it is true and accurate, and will be available for contact after submission. Employment letters and job descriptions may be verified by HR or medical staffing at the relevant hospital. A current hospital cannot verify evidence from another institution. [107]

The applicant completes the appropriate sections of a verification pro-forma, using the exact uploaded filenames and page counts, and the verifier completes their sections. One pro-forma is used per verifier, and the current guidance describes one verifier per institution for the evidence concerned.

Only list items the verifier can actually check. The GMC later contacts verifiers and may share a sample through GMC Connect. Evaluation does not proceed until required verifier responses have been received. Availability is therefore a real dependency, not a courtesy signature.

Some evidence does not require verification under the general guidance, including the CV, certain feedback, CPD certificates, public-domain publications, reflective notes and specified awards. These items still have to meet the application and SSG requirements and be supplied where relevant. ‘Does not need verification’ does not mean ‘proves capability by itself’. Always check the current pro-forma and specialty instructions because control requirements may be updated. [107]

Approach verifiers early with a bounded request. Explain the route, provide the GMC guidance, identify the institutional period and give a clean index of records. Ask whether they can access the source systems and remain contactable. Do not ask a former colleague to verify documents from an institution at which they no longer have the necessary access merely because they remember the work. If a suitable verifier cannot be identified, contact the GMC rather than constructing an improvised chain of signatures.

Overseas qualifications gained outside the UK need authentication under the current GMC guidance. An authenticated copy is stamped, signed and dated by a solicitor, notary or awarding body after comparison with the original. The GMC says not to send original certificates and currently requires authenticated evidence to be uploaded and then posted in hard copy after submission. Check the live process before action because delivery arrangements can change. [108]

Non-English evidence requires complete, accurate translation alongside the original-language document. The translation should show the translator or service’s contact details, and the original-language copy and translation should be stamped and signed as required. Documents needing both verification and translation follow a different sequence from qualifications needing authentication and translation. Follow the current GMC instructions in order; an applicant’s own translation or an informal summary is not enough. [108]

Maintain a control register for every item: identifier; institution; confidentiality checked; redaction completed and independently rechecked; verification required and verifier; authentication required; translation required; exact filename; page count; and status. Add dates. Before upload, sample the files from the destination copy rather than trusting the working folder. Opening the actual submitted file can expose a failed export, hidden page or mismatched version.

Never create retrospective clinical records for the application. A current supervisor may provide a truthful confirmation of what they directly know, if the SSG and GMC process permit it, but should not sign a reconstructed assessment as though it occurred years earlier. Keep original dates and describe retrospective evidence honestly. An acknowledged gap is safer than a document whose apparent provenance is false.

## Referees and attestations

Referees provide structured reports; they do not repair missing primary evidence. The live SSG sets the number and type required. The GMC recommends referees on the Specialist or GP Register or of equivalent standing unless the SSG says otherwise, while recognising that other grades may sometimes be nominated. Referees should have direct knowledge of the applicant's current expertise. A referee who cannot comment on a domain should say that they have no direct knowledge rather than infer from reputation. [109]

Select referees by coverage and observation. Create a matrix showing each referee's working relationship, dates, settings, outcomes directly observed, registration status and contact route. Look for collective coverage of the relevant breadth while obeying the SSG. Several prestigious referees from the same narrow clinic may leave important outcomes unsupported. A non-medical colleague may offer valuable evidence within their expertise, but the GMC warns that they may not be able to comment on clinical skills across the specialty unless the SSG provides for this.

Obtain consent before nomination. Give each referee the current curriculum, SSG, GMC referee guidance and an accurate CV. Discuss the route and the structured report process. Do not supply a pre-written favourable report. You may provide factual dates and an evidence index to help them locate what they know, but the judgement and examples must be theirs. A referee whose direct experience is limited should not be pressured to expand it.

Check administrative readiness. Confirm GMC numbers where applicable, ask registered referees to ensure their GMC Online details are current, and use professional contact details for non-registered referees as instructed. The GMC uses registered contact information for GMC-registered referees. A retired colleague, personal email or inaccurate number can delay the application even when goodwill is strong. [109]

Referee evidence should align with, not merely echo, the map. If Priya claims current breadth across settings but every referee knows only one setting, the mismatch requires action. A stronger adjective cannot solve it.

She may need additional current supervised work and a referee able to observe it, or she may need to reconsider readiness. The GMC explicitly advises delaying submission if suitable referees cannot be chosen.

Plan for absence and delay without collecting spare endorsements. Ask referees whether they expect to be available during the likely application period and whether a foreseeable retirement, leave or move may affect contact. If circumstances change, use the GMC route to update the application. Do not nominate an additional person outside the SSG merely as insurance or assume that a former supervisor can comment indefinitely. The structured report must remain based on direct, sufficiently current knowledge.

Read the eventual reports through the process permitted by the GMC; do not pressure a referee to remove legitimate limitations. If a report reveals a genuine evidence or relationship gap, address the gap. If it contains a factual error, use the appropriate correction route and preserve the correspondence. The aim is an accurate independent account, not uniform praise. A credible report may distinguish areas observed strongly from areas outside the referee's direct knowledge.

Distinguish referees from verifiers. A verifier confirms records from an institution through the required process. A referee comments in a structured report on expertise based on direct knowledge. One person might fulfil both roles if eligible and properly able to do so, but the functions remain separate. Do not assume that a referee's support validates every uploaded page or that a verifier's signature supplies an opinion across the curriculum.

Letters of support, testimonials and appraisal praise may be meaningful professionally but are not substitutes for the required structured reports. Keep them only where the SSG and application make them relevant. The evaluator needs specific, current, evidence-linked observations, not a campaign of endorsements. Priya asks each referee whether they can comment honestly on defined outcomes and accepts a limited answer. That conversation improves the application more than requesting universal support.

## Submission evaluation and possible decisions

Do not submit because the folder feels finished. Conduct four audits: route and source; outcome coverage; evidence control; and process readiness. Confirm the correct application and current curriculum. Trace every high-level outcome to sufficient evidence. Check redaction, filenames, pages, verification, authentication and translation. Confirm referees, verifiers,

contact details, fee and capacity to respond during the active process. Then ask a cold reader to navigate the map without verbal explanation.

The current GMC process begins with checks of eligibility, uploaded documents, verification pro-formas and referee nominations. If those checks pass, an adviser reviews the evidence. The GMC currently says adviser comments are provided within thirty calendar days. After advice, the applicant has thirty days to add or amend evidence; resubmissions within that period trigger further adviser review and reduce the remaining time. These timings were rechecked on 12 September 2026 and can change. The live application messages govern an individual case. [103]

The adviser's role is important but not a guarantee. Treat comments as a structured opportunity to address completeness, organisation and identified weaknesses. Respond once with a coherent revised submission where possible rather than repeatedly uploading fragments. If an item cannot be obtained within the period, explain the dependency and ask about the permitted options. Do not conceal a gap beneath more documents from unrelated domains.

The GMC then undertakes verification activity and gathers structured reports. An application becomes complete when required evidence, requested information, sampled verification and structured reports have been received. It is sent to the relevant Royal College, faculty or associate for evaluation. The GMC's current process page says the period before the case is complete and ready for evaluation can take three to six months, and that from referral for evaluation it takes up to three months to the final decision, with notification if longer. These are estimates, not promises. [103]

The evaluating body makes a recommendation; the GMC makes the final decision. A successful application means the assessment standards have been met and the doctor is entered onto the appropriate Register. Preserve the evaluation form and decision. Registration may satisfy one requirement for future roles, but the doctor must still compete for employment and establish a suitable scope, induction and job plan.

During processing, maintain a decision log. Record each request, the question it appears to answer, the owner, deadline, evidence supplied and confirmation of receipt. Keep the submitted version unchanged and prepare amendments as separately dated files. This prevents an urgent reply from introducing inconsistent dates or filenames. If the adviser's request is unclear, ask a focused question rather than guessing and uploading a large bundle. The individual GMC message overrides any general timetable quoted here.

Check professional circumstances while the application is active. A change of post, scope, licence, health affecting work, investigation or referee availability may alter information already supplied. Follow GMC instructions on notification rather than deciding privately that the change is irrelevant. Updating the regulator accurately does not predetermine the application outcome; failing to disclose a material change can create a separate problem.

If unsuccessful, the GMC provides reasons and recommendations identifying missing evidence or further training. Read the decision as a structured document. Map each recommendation to evidence, experience, process or interpretation. Obtain advice before choosing the next route. Emotional disappointment is real, but an immediate unstructured resubmission can repeat the same weakness.

The current guidance provides a review route within twelve months where the applicant has additional relevant evidence, has completed recommended training, or alleges procedural error or unfairness. It requires a new application because the earlier one is locked. There may also be a right of appeal; the GMC states that an appeal must be made within twenty-eight days of receiving the decision. Review and appeal answer different situations and can involve significant fees. The actual decision, current guidance and independent advice should control action. [110]

An appeal is not a general opportunity to replace weak evidence with an improved portfolio. A review may be more appropriate where new evidence or completed training addresses recommendations. A procedural challenge requires precise grounds. Do not miss a deadline while debating the merits informally. Record receipt date, obtain specialist advice promptly and keep the original submission, evaluation and correspondence unchanged.

The 2026 GMC specialist fee regulations set the Portfolio application fee at £1,974 from 1 April 2026. They also prescribe separate fees for specified extensions, fresh requests on new evidence and written or oral appeals, together with staged amounts retained if an application is withdrawn. Every figure is time-sensitive. Check the live regulations and payment page immediately before applying; do not budget from this chapter alone. [111]

After any decision, update the professional portfolio. Record what evidence remains useful, what should be securely disposed of under relevant policies, and which development work continues. Do not leave verifier copies and working bundles scattered across personal devices. If successful, continue appraisal and revalidation normally. Specialist registration is not permanent proof that every clinical competence remains current; scope and governance still need active maintenance.

## Cost time support and resilience

The direct fee is only one cost. Applicants may face authentication, translation, travel, courses, placements, professional advice, secure document preparation and time away from ordinary work. Some employers provide Portfolio Pathway support or development funding; others do not. Establish what is available in writing and what conditions apply. Do not incur major expenditure because a commercial service implies that success depends on purchasing its package.

Build a realistic time budget. Map the work into curriculum analysis, evidence retrieval, development, assessment, redaction, verification, referee preparation, upload and response periods. Much of the burden occurs outside writing. An hour spent securing a legitimate placement or institutional verifier may be more important than an hour polishing a summary. Protect regular, bounded time where possible rather than relying on a final period of nights and weekends.

Employer support should connect to service and capability. Ask for a named supervisor or mentor, access to required clinical settings, appropriate assessments, data and educational opportunities, administrative help with historic records, and job-plan time where agreed. The employer cannot promise GMC success. It can create fair opportunities and provide accurate evidence of work. If support is declined, ask which component cannot be provided and whether an alternative exists.

Choose support roles clearly. A mentor helps the applicant think and sustain progress. A specialty supervisor observes and develops practice. A former successful applicant offers practical perspective. A Royal College adviser may interpret specialty development. A trade union advises on employment support. The GMC adviser works within the application process. No single person should be treated as unofficial decision-maker, verifier and editor of the entire case.

Commercial courses and portfolio-review services vary. Before paying, ask whether advice is based on the live SSG, who provides it, what confidentiality arrangements apply, whether the service has a conflict of interest, and what it can genuinely deliver. Never upload confidential patient or employer material to an unapproved platform. A polished template cannot compensate for absent capability, invalid verification or unsafe disclosure.

The emotional burden should be planned rather than minimised. The application can expose gaps in a career in which the doctor has nevertheless contributed greatly. Organisational delay may feel like a judgement on worth. An unsuccessful decision can be painful. Separate identity from

assessment: the decision concerns evidence against a defined regulatory standard at a particular time. Seek peer, professional and wellbeing support early, especially if the process is affecting sleep, health or clinical concentration.

Use stop and review points. At three-monthly intervals ask whether the chosen specialty remains right, the current role can generate required evidence, sources have changed, verifiers remain available, cost remains manageable and the destination still justifies the burden. Pausing to obtain experience is not failure. Abandoning an unsuitable route can be a sound career decision. Continuing solely because much effort has already been spent is a sunk-cost error.

Priya's original portfolio contains nearly two thousand pages. Much is old, duplicated or dominated by appraisal summaries. After mapping, she removes irrelevant material from the active application set. She identifies two clinical breadth gaps, limited current education evidence and an inaccessible verifier from a former institution. She delays opening the application, negotiates one supervised placement, develops a teaching project, obtains authorised historic records and confirms current referees.

Eighteen months later, her application set is smaller but stronger. Each high-level outcome has a clear evidence route, old material is used only where the SSG permits and current evidence demonstrates maintenance, files are permanently redacted, verification is institution-specific, and referees know the curriculum through direct work with her. She still cannot know the decision in advance. She can know that she has followed the live process and presented her practice honestly.

Her final submission audit has twelve questions. Is the application route confirmed? Are curriculum and SSG versions current? Is every high-level outcome mapped? Is clinical breadth, depth and recency demonstrated? Do non-clinical domains contain primary evidence of contribution and outcome? Are gaps resolved rather than disguised? Is every file necessary, readable and correctly named? Is redaction permanent? Are verification, authentication and translation correct? Are referees eligible and directly informed? Can the applicant respond during the process? Have the fee and possible next decisions been checked today?

The pathway rewards disciplined preparation more than accumulation. Its deeper professional value lies in making a career legible: what the doctor can do, where that capability was developed, how it has been maintained, which evidence can be trusted and where limits remain. Registration is the GMC's decision. The applicant's responsibility is to choose the correct

standard, build the experience, protect confidentiality and submit an honest, navigable case.

The distinction at the centre of Part Five now remains visible. Wales and Scotland have their own progression or regrading policies. England and Northern Ireland use competitive Specialist appointments to employer-created posts. The Portfolio Pathway is a UK regulatory route to specialist registration. These destinations can support one another, but none should be presented as an automatic substitute for another. A doctor progresses most safely when the desired destination is named before the evidence journey begins.

Chapter 19

# Leadership education and supervision

## Leadership already present in SAS practice

Kavita is a composite senior Specialty Doctor in a busy medical service. Colleagues ask her to settle difficult operational decisions, new doctors seek her advice, and managers depend on her to maintain continuity when senior staff change. She organises teaching, reviews incidents and has redesigned part of the referral pathway. None of this appears as a defined responsibility in her job description. Her job plan records clinical activity and a modest allocation for supporting professional activity, but says nothing about service leadership or supervision. When a new clinical lead is appointed, Kavita is thanked for “helping out”. She has influence and responsibility, but uncertain authority, no protected time and little evidence assembled for future progression.

Many SAS doctors will recognise some part of this pattern. Leadership begins before appointment to a leadership title. It may be visible in coordinating a deteriorating service, bringing different professions to a safe decision, identifying an unsafe gap, improving a pathway, helping colleagues work through uncertainty or maintaining standards when systems are under pressure. Education may begin with bedside explanation, induction or feedback before it becomes a named faculty role. Yet it is unhelpful to label every competent act as leadership. Good clinical practice, collegiality and leadership overlap, but they are not interchangeable.

The practical question is not, “Am I a leader?” It is, “What work am I doing, what result am I responsible for, and under whose authority?” This keeps the discussion grounded. A doctor who chairs a meeting may be facilitating rather than deciding. A doctor who notices a recurring problem may contribute evidence without owning the remedy. Conversely, a doctor with no formal title may be making decisions on which the service repeatedly relies. Accurate description protects against both inflation and invisibility.

The GMC expects doctors to contribute to supportive, fair and safe working and learning environments, to use resources responsibly and to raise concerns where patient safety may be compromised. These duties apply in proportion to a doctor’s role; they do not turn every doctor into the accountable manager for organisational failures.[3] A leadership record

should therefore separate professional conduct expected of all doctors from an additional role carrying defined deliverables and accountability.

Start with observable verbs. “Provided senior clinical coordination during the winter escalation period” is clearer than “showed leadership”. “Designed the induction timetable, recruited faculty and reviewed learner feedback” is stronger than “led education”. Record the setting, dates, people accountable, your contribution, decisions made and what changed. The same discipline used in Chapter 12 for a professional portfolio makes everyday leadership legible without exaggerating it.

Kavita maps one month of work. She discovers that her informal contribution includes a weekly operational meeting, preparation for two teaching sessions, supervision conversations, review of safety reports and repeated calls from colleagues about a pathway for which she has no formal decision right. The map does not prove that every activity deserves a separate programmed activity. It establishes that recurring work exists and allows a proper conversation about purpose, authority, time and evidence.

This chapter is not a condensed substitute for *SAS Leadership in Practice*. That book examines leadership behaviour, power, systems, difficult conversations and organisational change in greater depth. The present task is narrower: to convert contribution into a safe, governable role; distinguish teaching from approved supervision; demonstrate useful impact; and build continuity so that neither the doctor nor the service becomes dependent on unrecorded labour.

Recognition may lead to several different actions. Some contribution belongs within ordinary professional practice and needs only accurate portfolio evidence. Some requires a clearer local mandate. Some has become a substantial recurring duty that should enter the job plan. Some should be stopped because it duplicates another role or lacks governance. The map is therefore a decision tool, not an argument that every helpful action warrants a title. Its value lies in matching the response to the work.

## Formal authority role description and accountability

A formal title is valuable only when it clarifies the work. “SAS lead”, “education lead”, “service lead” or “clinical coordinator” can mean different things between organisations. Before accepting a role, ask for a short written description that identifies its purpose, scope, authority, reporting line, term, objectives, resources and review arrangements. If the role already exists informally, use the same questions to convert it into a discussable proposal.

Purpose answers why the role is needed. Scope identifies the services, professions, sites and decisions covered. Authority specifies what the holder

may decide, recommend, approve or escalate. Accountability names the person or committee to which the role reports. Resources include time, administrative help, information, budget, access to systems and deputy cover. Review arrangements establish how priorities may change and how the role can end or transfer. These are not bureaucratic decorations. They prevent responsibility being assigned without the means to discharge it.

Decision rights deserve particular attention. A doctor may gather information and recommend a rota change while another manager has authority to approve it. A clinical lead may set a professional standard but lack authority to employ staff or purchase equipment. An educational supervisor may guide a learner but not make a programme-level progression decision alone. Write the boundaries down. If the role-holder is expected to act in an emergency, identify the immediate authority and the later reporting requirement.

The reporting line should remain usable when the matter concerns the usual manager. A role description can say that routine work reports to the clinical director, with unresolved safety, conduct or resource concerns escalated through a named alternative route. This does not guarantee agreement; it prevents the role from depending on one relationship. Where a role spans organisations, specify who owns each decision and how conflicting instructions will be resolved.

Objectives should describe deliverables that the role can influence. “Improve morale” is too broad for one doctor. “Establish a quarterly multidisciplinary review of two recurring operational risks, agree actions with named owners and report progress to the governance committee” is assessable. Measures can include completion, timeliness, participation, learning or an agreed service outcome, but should not attribute system-wide results to an individual who controls only one component.

The appointment process also matters. Establish whether the role is substantive, fixed term, rotational or acting; whether it was advertised; what preparation is expected; and how performance will be reviewed. A temporary role should have an end point and handover expectation. An acting appointment should not become indefinitely permanent by silence. If the organisation needs continuing responsibility, it should decide how the enduring role is authorised and resourced.

Professional accountability continues alongside organisational accountability. GMC guidance on leadership and management explains that doctors with management responsibilities remain accountable for their decisions and should be clear about roles, resources and risks.[47] It does not follow that the doctor becomes personally accountable for every outcome

within the service. Record advice given, decisions made by others, constraints reported and action taken within your control. Escalate when the role's authority or resources are inadequate for a material risk.

Kavita proposes a service-development role rather than seeking retrospective praise. The one-page description names three outputs: coordinating a pathway review, reporting agreed measures to governance and maintaining an induction package. It excludes line management, rota approval and final budget decisions. It identifies the clinical director as accountable sponsor, the governance committee as reporting forum and a twelve-month review. The document turns a vague expectation into something both sides can test.

Before accepting, run a failure test. Imagine that the principal objective has not been delivered after six months. What explanation would the organisation reasonably expect from the role-holder, and which missing powers or dependencies could have prevented delivery? If the answer includes recruitment, budget, data or decisions controlled entirely by others, the role description must show how those dependencies will be managed. Ask what happens when the sponsor is absent, priorities conflict or an agreed action is refused. A role is not properly defined if accountability becomes clear only after something goes wrong.

Also establish how concerns about the role-holder will be handled. A leadership appointment should not place ordinary performance discussion, employment management and professional conduct within one vague process. The doctor should know who reviews objectives, which policy applies to employment concerns, and how regulatory or patient-safety matters are routed. This protects fair challenge. Clear accountability is not a shield from scrutiny; it ensures that scrutiny occurs through the correct mechanism and against an agreed remit.

Use this role-definition sheet:

Role title and term: What is the role called, when does it start and when is it reviewed or ended?

Purpose and scope: What problem or function does it address, across which services, sites and groups?

Authority: What may I decide, recommend, approve, delegate or escalate? What remains with someone else?

Accountability: Who is my responsible sponsor? Which committee receives assurance? What is the alternative escalation route?

Outputs and measures: What will be produced or changed, by when, and how will contribution be assessed?

Resources: What time, information, administrative support, training, budget and deputy capacity are agreed?

Boundaries: Which tasks are outside the role? What happens if expectations expand?

Handover: What records, relationships and decisions must be transferable at the end?

## Securing time in the job plan

Leadership, education and supervision consume real time. Preparation, reading, meetings, documentation, follow-up and travel do not disappear because the visible event lasts one hour. Chapters 6 and 7 explain the contractual and evidential method in detail. Here, the essential step is to translate the proposed role into activities, frequency, duration, location and outputs, then take that evidence into the applicable job-planning process.

Begin with a prospective workload rather than a desired number of sessions. For a monthly governance meeting, record agenda review, data interpretation, the meeting itself, agreed follow-up and reporting. For an educational role, include learner meetings, review of evidence, written reports, liaison with the training programme, educator development and urgent concerns. Distinguish predictable work from genuinely exceptional demand. Annualise activities that occur irregularly and state the assumptions.

Supporting professional activity terminology and contractual arrangements differ across nations and contracts. The UK SAS job-planning guide provides a practical framework, while current terms and local processes govern the individual agreement.[33] Do not assume that a familiar allocation from another organisation transfers automatically. Equally, do not allow the absence of a universal number to turn recurring work into unpaid or invisible work. The case should rest on agreed duties and time required.

Avoid double counting. If a teaching session occurs during a clinical session and the planned clinical workload is reduced accordingly, record the arrangement once. If supervision happens informally while clinical work continues at full intensity, that may indicate the need to redesign the timetable rather than to claim the same hour twice. The objective is a safe operating agreement, not the largest possible total.

Show opportunity cost. A weekly hour of supervision may require more than an hour removed from another activity once preparation and documentation are included. If no clinical activity is displaced, ask what work will no longer be done or who will provide it. This reveals whether the

proposed role has been resourced or merely added. Where patient-facing work must continue, the service may need backfill or a staged start.

Link time to outputs. Kavita's proposed role includes a protected weekly block for pathway work and a smaller annualised allowance for induction. The proposal identifies the reports, meetings and review points supported by that time. It also says that substantial new work will trigger job-plan review. This is stronger than asking for recognition in the abstract because the organisation can see what it is agreeing to receive.

Record employer dependencies. A leadership objective requiring data analysis depends on access to validated information. A supervision objective may depend on an eligible learner, approval by the relevant training body and access to the required platform. If the dependency is not delivered, record it at review rather than treating the objective as a personal failure. Where duties materially change, use the review, mediation or appeal arrangements of the applicable contract and local process rather than allowing disagreement to remain informal.

Do not postpone the conversation until appraisal. Appraisal can reflect on the role and identify development needs, but it does not amend the employment contract or allocate organisational resources. The job plan is the operating agreement for recurring work. The role description explains authority. The portfolio evidences contribution. Keeping these documents connected but distinct prevents one favourable appraisal sentence being mistaken for employment agreement.

Prepare the discussion as a service proposal. Bring the agreed role description, a representative work diary, annualised assumptions, the timetable consequence and two options. One option might protect a recurring block and reduce another duty; another might narrow the leadership remit to what existing time can support. State the safety or continuity risk if neither is possible without presenting every disagreement as misconduct. Ask that the decision, reasons and review date are recorded. A staged trial can be sensible when workload is uncertain, provided it has a defined measure and does not become an indefinite experiment.

Review delivery as well as allocation. Protected time can be repeatedly displaced by vacancies, urgent clinical demand or meetings scheduled elsewhere. Record when this happens and what work is deferred. A nominal allocation that cannot be used is not the same as functioning capacity. Equally, if the work takes less time after a process improves, the job plan can change. Evidence supports a credible agreement in both directions.

## Clinical and educational supervision

Teaching, clinical supervision and educational supervision are related but different. Teaching may be a planned learning event. Clinical supervision supports safe patient care and development in a particular clinical setting. Educational supervision takes a broader view of progress over time within a defined educational programme. Local titles vary, so establish the actual function rather than inferring it from the label.

The first question is who the learner is and under what framework they are working. A resident doctor in a GMC-approved postgraduate programme has programme requirements, a curriculum and formal governance routes. A locally employed doctor, medical student, advanced practitioner or colleague developing a new skill may be supported under different organisational or professional arrangements. A doctor experienced in teaching one group is not automatically authorised to perform every assessment or sign every outcome for another.

For formal postgraduate medical training roles, the GMC's trainer-recognition framework covers named clinical supervisors and educational supervisors in recognised settings. Local education organisers and postgraduate deans implement recognition and approval arrangements; the employing organisation alone cannot make a signature valid for a programme by giving someone an informal title.[112] Before taking responsibility, confirm the role's recognition status, required preparation, continuing development, appraisal evidence and access to programme systems. Nation, specialty and training programme arrangements may add requirements.

The GMC's *Promoting excellence* standards place patient safety and the quality of the learning environment at the centre of medical education. Organisations must provide appropriate supervision, resources and governance, while learners must know how to raise concerns.[113] These are organisational as well as individual responsibilities. A supervisor should not accept an unsafe ratio, unknown scope or unmanageable workload on the assumption that personal vigilance can compensate indefinitely.

At the start of a supervisory relationship, clarify purpose, frequency, availability, confidentiality boundaries and escalation. Review the learner's role, previous experience, intended outcomes and local scope. Agree what the learner may do independently, what requires direct or indirect supervision and how urgent help is obtained. These arrangements should reflect competence and context, not grade title or confidence alone. They must change when evidence changes.

Clinical supervision is active. It includes making sure that the learner understands local systems, providing accessible senior input, observing practice where required, calibrating entrustment and responding to concern. “Call me if worried” is not an adequate plan if the learner cannot recognise the threshold for calling or fears an adverse response. Use explicit triggers: particular clinical presentations, unexpected deterioration, uncertainty outside agreed scope, conflict in advice or system failure.

Educational supervision includes longitudinal review. It should examine evidence against the relevant outcomes, feedback from different settings, the learner’s reflections and agreed development. The supervisor facilitates an honest account; they do not guarantee progression or rewrite weak evidence. Where the role involves formal reports, complete them accurately and on time. Distinguish direct observation from information reported by others, and identify uncertainty rather than smoothing it away.

Feedback should be specific enough to guide action. “Needs more confidence” is ambiguous and can reproduce bias. Describe the observed situation, behaviour, consequence and expected next step: for example, the learner’s presentation omitted the medication history needed for a safe prescribing decision; at the next observed review, use the agreed structure and explicitly reconcile current medicines. Invite the learner’s view and consider whether workload, induction, language, health, disability or supervision design contributed. Explanation is not the same as lowering a necessary safety standard.

When performance or conduct causes concern, act within the framework. Address immediate patient safety, document factual observations, seek advice from the educational lead or training programme and tell the learner what can appropriately be shared. Do not conduct an amateur investigation beyond your remit or make a high-stakes progression decision alone. A supervisor may need to escalate even when the learner would prefer confidentiality. Those boundaries should have been explained at the outset.

The reverse problem also matters: an educator may receive a concern about the learning environment or a senior colleague. Listen without promising secrecy that cannot be kept. Clarify immediate safety and what the learner is asking for. Record and route the concern through the appropriate educational, clinical or speaking-up system. A learner should not be left to confront a powerful individual simply to demonstrate resilience.

Supervisor evidence should include recognition or approval where applicable, preparation, agreed duties, learner meetings, formal reports, feedback on the educator role and continuing development. Preserve only

appropriate records in approved systems. Do not copy identifiable learner material into a personal portfolio merely to prove activity. An authorised confirmation, aggregate evaluation or role record may provide safer evidence.

The Academy of Medical Educators' professional standards offer a useful developmental framework across planning, teaching, assessment, scholarship and educational leadership.[114] They are not a substitute for the specific approval rules of a programme. Use them to identify development needs: perhaps the doctor delivers strong teaching but has little experience of assessment design, supporting a struggling learner or evaluating an educational programme.

Kavita is asked to "sign off" a locally employed doctor's competence after several informal conversations. She first establishes what the sign-off will be used for, who owns the process and what evidence is required. She can confirm what she directly observed, but refuses to certify unobserved practice. The organisation then creates a defined developmental-supervision arrangement with appropriate assessment, named accountability and time. Her caution protects the learner as much as the service.

## Teaching that produces evidence

A teaching record becomes useful when it shows more than attendance and satisfaction. Begin with a learning need. This may arise from a curriculum, governance finding, learner request, service change or observed gap. Describe whose need it is and what evidence supports it. A broad statement such as "staff need sepsis teaching" is less useful than identifying a recurring difficulty in the recognition and escalation process for a particular learner group.

Write outcomes that describe what learners should be able to do. Choose a method suited to those outcomes. A short explanation may support knowledge; a worked case may test reasoning; supervised practice may be needed for performance. The educator should also consider accessibility, prior experience, group size, psychological safety and the effect of teaching on patient care. One method will not suit every need.

Evaluation should match the claim. Attendance shows reach. Immediate feedback explores learners' experience and perceived relevance. A knowledge check can examine defined learning outcomes. Observation may examine performance. Later review may explore whether practice changed, but many other factors affect service outcomes. Do not claim that a popular session reduced harm unless the evidence can support that conclusion.

Kavita redesigns induction after new doctors repeatedly struggle to locate escalation contacts. Her teaching file contains the identified problem, objectives, revised guide, attendance, a brief scenario exercise and anonymous aggregate feedback. Six weeks later, she asks a small sample of doctors to demonstrate how they would escalate three situations and identifies one persistent gap. She revises the guide. The evidence supports responsive educational design and evaluation. It does not prove that she eliminated every escalation delay.

Credit co-design. If administrators produced the guide, nurses developed a scenario and learners suggested the clearest format, say so. Leadership evidence is not strengthened by absorbing other people's work into a single heroic account. Fair attribution shows the ability to mobilise expertise and respond to feedback.

Use a compact teaching evidence record:

Need: What learning problem was identified, for whom and from what evidence?

Outcome: What should learners be able to explain, decide or do afterwards?

Design: Why was this method chosen, and how were accessibility and learner context addressed?

Delivery: What did I contribute, what did others contribute and what changed from plan?

Evaluation: What was measured, what did it show and what could it not show?

Improvement: What will be retained, revised, stopped or tested next?

Governance: Was approval required, were patient or learner data protected and where is the authorised record held?

This creates material for appraisal, educational-role review and competitive applications. Select and explain it for each purpose rather than submitting every slide. A teaching certificate or complimentary email may be included, but neither replaces the account of need, method, evaluation and learning.

Faculty and assessment work require the same precision. Writing one draft question, examining in a structured clinical assessment, contributing to standard setting and chairing an assessment board are different responsibilities. Record the brief, preparation, calibration, quality-assurance process and decision boundary. Do not retain secure assessment material in a personal portfolio. An authorised confirmation of the role and a reflection on learning may be sufficient evidence without compromising examination integrity.

Inclusivity should be designed rather than added after a complaint. Consider timing for less-than-full-time learners, access needs, language load, religious observance, remote participation and whether examples assume knowledge of one NHS culture. Test materials with the intended group. Adapting a method to remove an irrelevant barrier does not remove the clinical or professional standard being taught. Record both the standard and the adjustment.

An educator also needs development. Ask for observation by an experienced colleague, review learner feedback for patterns and identify one deliberate change. A short cycle—plan, deliver, receive feedback, adapt, deliver again—produces better evidence than a list of repeated sessions. If the educational role becomes substantial, consider a recognised programme or peer framework appropriate to the organisation, while remembering that an additional qualification does not itself confer programme authority.

## Service improvement and governance leadership

Improvement leadership connects a defined problem with a responsible process for change. It begins with understanding the system, not announcing a solution. Identify the population or pathway affected, the evidence of the problem, the people who perform the work and those who experience its consequences. Establish who owns the risk and who has authority to approve a test. Governance provides the route through which decisions and learning are recorded.

Do not confuse audit, quality improvement, service evaluation and research. Local governance arrangements determine classification and approval, and the same project may involve more than one method. Before collecting data or altering practice, establish what review, information-governance and ethical arrangements apply. A portfolio description should use the classification actually agreed, not whichever label appears most prestigious.

Kavita's pathway review concerns delayed clinical responses to a category of referrals. She resists the request to "fix referrals" alone. The team maps the process and finds several contributing factors: inconsistent referral information, unclear ownership after transfer, variable access to senior advice and no shared measure. Kavita helps define a limited first test, while the operational manager owns staffing and the information team validates the data. The governance committee agrees the risk and review point.

Her leadership contribution can be traced from problem definition through decision, implementation and review. She records the evidence

considered, options rejected, assumptions, responsibilities and measure. When the first change improves completeness of referrals but lengthens administrative processing, the team adapts it. The mixed result becomes evidence of judgement because the record shows learning and correction rather than a manufactured success story.

Measures need a denominator, period and limit. Suppose complete information is present in 21 of 35 sampled referrals before the change and 29 of 35 afterwards: 60 per cent and approximately 83 per cent. The increase is 23 percentage points, but the sample does not establish causation or sustained performance. If time to response did not improve, the team should not imply that documentation alone solved the safety concern. This disciplined explanation makes the evidence more credible.

Governance leadership also means ensuring that unresolved risk remains visible. If the service accepts a temporary mitigation because the preferred resource is unavailable, record the accountable decision, review date and trigger for escalation. Do not let a doctor's repeated informal rescue obscure the underlying system weakness. Conversely, avoid turning every operational inconvenience into a governance crisis. Describe severity, likelihood, affected process and existing controls as accurately as the evidence permits.

Connect improvement with the job plan. Data review, stakeholder work, testing and reporting require time. Once a new process becomes routine, identify who owns maintenance. A project allocation should not silently become permanent oversight. If Kavita is expected to receive monthly data and intervene when performance falls, that is continuing work requiring a defined owner, authority and resource.

The leadership evidence record can use seven rows: problem and evidence; agreed role; stakeholders and authority; actions and decisions; measures and findings; learning and adaptation; continuing ownership. Attach or locate the authorised primary records. Add a two-sentence claim describing what the evidence justifies. This produces a stronger portfolio entry than a slide saying that Kavita "transformed the pathway".

Patient and public involvement may improve understanding of the problem, but it must be meaningful and supported. Do not invite a patient to endorse a predetermined solution or include identifiable testimony without the required agreement. Record how views affected decisions and where they did not, with reasons. Improvement leadership includes handling disagreement honestly.

Close the loop visibly. A governance paper should state what the team agreed, who owns each action, what assurance remains incomplete and

when the issue returns. If a recommendation is rejected, record the accountable decision and the alternative control. If it is accepted but not implemented, distinguish approval from delivery. This prevents meeting attendance from becoming a proxy for improvement.

Sustainability needs an explicit test. Can the measure be produced without exceptional manual work? Do staff understand the new process? Has unintended work shifted to another team? Is the benefit still visible after the initial attention fades? Has the responsible owner accepted ongoing review? A promising pilot may properly remain a pilot when these questions are unanswered. The leadership achievement can be the identification of those limits and a proportionate decision not to scale prematurely.

Where the project crosses organisations, information, money and authority may travel through different routes. Establish a sponsor in each organisation, a common problem statement and a method for resolving incompatible priorities. Do not assume that agreement in one committee commits another employer. Shared governance records should make clear which organisation has accepted which action.

## Leading across status and professional boundaries

SAS doctors often lead where formal hierarchies and practical expertise do not align. A senior SAS doctor may know a service more deeply than a newly appointed consultant, while lacking the consultant title assumed by some colleagues to carry authority. A nurse, pharmacist, administrator or therapist may hold essential operational knowledge that a medical leader lacks. Good leadership uses role, expertise and accountability explicitly rather than allowing status to decide whose evidence counts.

Before a difficult decision, map the relevant forms of power. Formal authority permits certain decisions. Expertise makes advice credible. Control of information, access, relationships or resources also shapes outcomes. A respected long-serving doctor may have considerable informal influence. None of these forms of power is inherently improper, but unacknowledged power can silence challenge or produce compliance mistaken for agreement.

Use language that makes participation possible. State the decision to be made, what is fixed, what remains open and who decides. Invite evidence from those closest to the work before the most senior voice frames the answer. Ask for disagreement specifically. Close the meeting by recording the decision, reasons, owner and review point. These simple disciplines reduce dependence on personality.

Grade-based assumptions deserve challenge in both directions. A Specialty Doctor should not be excluded from a role merely because colleagues associate leadership with consultancy. Nor should long service be treated as proof of readiness for any leadership position. Use the role requirements and evidence of capability. The same principle applies to internationally qualified colleagues, less-than-full-time doctors, disabled doctors and people whose influence has developed outside familiar networks.

When authority is ambiguous, say so early. Kavita can advise on a clinical standard while the manager decides staffing; if the staffing decision leaves a risk, she records her clinical advice and uses the governance route. She should not present the manager's decision as her own, but neither should she withdraw from helping the team implement the safest available arrangement. Professional disagreement and organisational cooperation can coexist.

Fair leadership includes access to opportunity. Teaching invitations, acting roles and committee membership often travel through informal sponsorship. Keep a transparent record of how opportunities are offered, what criteria apply and how people can express interest. Rotating chairing, presentation and project roles can develop capability when the work and support are real. Token participation without information or decision access is not development.

Feedback on leadership should come from more than the person who appointed the leader. Seek proportionate views from people affected by the role and examine objective evidence of delivery. Ask what enabled colleagues to contribute, where decisions remained unclear and what the leader should change. Do not conduct an uncontrolled popularity poll or collect identifiable comments without a safe process. The purpose is learning and assurance.

Where conflict arises, separate the issue from identity. A colleague may challenge Kavita's proposal, her authority or the process. She should ask which claim is disputed and what evidence would resolve it. If behaviour becomes disrespectful or discriminatory, Chapter 20 provides different routes. Leadership does not require absorbing mistreatment as the price of influence.

Sponsorship and challenge can coexist. A senior colleague who opens access to a committee should not expect loyalty to every proposal. Set the professional boundary before a contentious decision: support gave access, not ownership of judgement. Similarly, when sponsoring someone else,

describe their work accurately and do not expect them to reproduce your style. The purpose is to widen participation and capability.

Notice who performs the relational work. Translating between groups, calming conflict, welcoming new staff and repairing communication are often essential but poorly recorded. These contributions should be recognised without assigning them automatically to women, minority colleagues or the person seen as most accommodating. Rotate and resource them where possible. Emotional steadiness is valuable; permanent emotional labour is still work.

A useful meeting audit asks four questions: who had the information before the meeting, who spoke first, whose evidence changed the decision and who received the resulting work? Repeated patterns may reveal that nominal inclusion is not effective participation. Change the process—circulate papers, invite frontline evidence, assign actions by authority and check distribution—rather than asking under-heard colleagues simply to speak more confidently.

## Succession and distributed capability

A service that can function only when one individual is present is fragile, however capable that individual may be. Succession is therefore part of current leadership, not a task reserved for retirement. It means distributing knowledge, preparing others to exercise defined responsibilities and leaving records from which safe decisions can continue. It does not mean naming a preferred successor outside a fair appointment process.

Identify the work that currently depends on you. Include recurring decisions, key relationships, access rights, tacit knowledge, deadlines and risks. Mark what can be standardised, taught, delegated or shared. Some responsibilities require a formally authorised deputy; others can be distributed among team members. If no one else can perform a safety-critical task, put that dependency on the risk and workforce agenda rather than celebrating indispensability.

Develop deputies through graduated responsibility. Observation alone rarely creates readiness. Agree a task, authority, supervision and review; allow the colleague to make real decisions within that boundary; then discuss the reasoning and outcome. Avoid giving the deputy responsibility without access to information or excluding them from meetings where future decisions are shaped. Record development fairly for their portfolio as well as your succession plan.

Create a living handover. It should explain the role’s purpose, current priorities, decision calendar, governance routes, unresolved issues, key

documents and access arrangements. Distinguish facts from your interpretation. Do not create an uncontrolled file of confidential correspondence. Link to approved records and state who may access them. Review the handover while you are still in post by asking another informed person to use it.

Kavita's original service had no deputy because colleagues assumed she would always be available. Her new role description includes deputy development as an output. She invites expressions of interest against transparent criteria, agrees a rotating arrangement and shares chairing and reporting. One colleague develops the induction programme; another learns the pathway data. Kavita retains accountability where required, but the service begins to own its own processes.

Succession also requires permission to let others work differently. A deputy who follows every instruction but never exercises judgement has not been prepared. Agree the non-negotiable standards and the area in which they may choose another method. Review the reasoning, including decisions that differ from yours. Correct unsafe practice promptly, but do not mistake personal preference for governance.

Plan for several timescales. Immediate resilience covers unexpected absence. Medium-term development prepares colleagues to share recurring work. Formal succession addresses the end of an appointment and any recruitment process. The same person need not cover all three. A temporary deputy may hold operational knowledge while a competitive appointment identifies the next substantive lead.

When departure is known, protect time for transfer. List open decisions, upcoming deadlines, significant relationships, current risks and records requiring access. Introduce the successor or interim holder to the relevant forums. Close personal workarounds, such as information sent only to an individual inbox, and replace them with authorised team processes. Agree what support, if any, the outgoing leader will provide after handover so that advice does not become continuing shadow accountability.

The succession checklist is short:

Critical functions: Which decisions or relationships fail if I am absent?

Authority: Who may act, within what boundary, and where is that recorded?

Capability: Who needs observation, practice, feedback or formal preparation?

Information: Which current records, deadlines and risks must be accessible?

Continuity: What cover exists for leave, illness and role transition?

Fairness: How will development and appointment opportunities be offered transparently?

Review: When will the deputy exercise the role, and how will learning be evaluated?

Handover: What must be transferred, closed or escalated when the role changes?

Kavita's final leadership evidence record now contains more than a title. It shows the agreed remit, job-plan time, governance reports, educational design, feedback, adaptation and the development of deputies. It also records constraints and work owned by others. She can use this evidence in appraisal and future applications without claiming sole credit. More importantly, the service is less dependent on her invisible labour.

The reader's next action is to choose one recurring contribution and complete the role-definition sheet. If it is already agreed, test whether time, authority and succession match the expectation. If it is informal, decide whether it should become a defined role, return to ordinary shared work or stop. Leadership becomes sustainable when contribution is recognised accurately, responsibility is governable and capability remains after the individual moves on.

Chapter 20

# Workplace dignity support and speaking up

## Name the problem carefully

Amina is a composite Specialty Doctor in an NHS service. She repeatedly reports that abnormal investigation results can remain unallocated after a rota handover. The immediate clinical concern is eventually reviewed, but she is then omitted from meetings at which the pathway is redesigned and an agreed development opportunity is given to someone else without explanation. A colleague tells her that she has become “difficult”. Amina experiences the sequence as punishment for speaking up. Her manager says the exclusions were unrelated operational decisions. At this stage, neither interpretation is proved.

The first task is to separate events that may require different responses. A patient-safety concern asks whether people could be harmed and what action is needed. An employment concern asks whether Amina has been treated fairly under the relevant contract and policies. A discrimination question asks whether treatment was connected to a legally protected ground or took a legally prohibited form. A conduct concern asks whether behaviour breached professional or organisational standards. These questions may overlap, but one label should not be expected to decide them all.

Difficult management is not necessarily bullying. A manager may set a demanding objective, challenge performance, refuse a request or make an unpopular service decision properly. Incivility includes disrespectful or discourteous behaviour that may damage working relationships even when it does not meet a policy or legal definition. Bullying commonly describes offensive, intimidating, malicious or insulting behaviour, or misuse of power that undermines or harms, but the governing employer policy matters and UK employment law does not provide one universal free-standing claim called “bullying”.[115]

Harassment and discrimination are not synonyms for unfairness. In Great Britain, equality law gives specific meanings to discrimination, harassment and victimisation connected with protected characteristics or protected acts. Northern Ireland has a distinct body of anti-discrimination legislation and institutions; do not assume that an Equality Act explanation applies

unchanged there.[115][116] Individual legal conclusions depend on facts, status, jurisdiction and timing.

Victimisation in equality law and detriment after whistleblowing are also different legal concepts, although ordinary language may call both retaliation. A doctor may suffer adverse treatment after making a complaint without every legal condition being satisfied. Conversely, apparently minor changes—loss of information, exclusion from opportunity or altered duties—may matter when viewed as a documented pattern. Describe the acts first, then seek advice on the correct label.

Use a five-line problem statement: what happened; when and where; who did or decided what; what effect followed; and which issue now needs a decision. Amina writes: “After I submitted the safety report on 12 May, I was not invited to three pathway meetings I had previously attended. On 3 June the education role discussed in my development review was assigned without an advertised process. I need the service to address the unresolved handover control, explain these decisions and confirm how future opportunities will be allocated.” This is more actionable than “management is bullying me for whistleblowing”, while preserving the possibility that advice may later support stronger terminology.

Separate impact from conclusion. “I felt humiliated when the criticism was delivered in front of the team” records a real personal effect. “The purpose was to humiliate me” asserts intention. “My clinic was removed after I raised the issue” records sequence. “My clinic was removed because I raised it” asserts causation. Both conclusions may eventually be supported, but keeping the distinction clear makes the initial account more reliable.

A route selector begins with the remedy. If the immediate need is a clinical control, use a safety route. If it is an explanation of a management decision, use the employment line. If it is investigation of behaviour, consult the dignity or grievance policy. If it concerns a protected ground, obtain equality advice. If it is public-interest wrongdoing, examine speaking-up and whistleblowing routes. The same facts can be signposted between processes without being indiscriminately submitted to all of them.

## Status power and repeated patterns

Workplace harm is rarely understood from one event alone. A curt email may be poor communication. Repeated public criticism, selective scrutiny, withholding of information and removal of opportunity may form a pattern. The assessment should consider frequency, context, effect, comparator evidence and the organisation’s response after concerns were raised. It should not invent motive where the evidence shows only behaviour.

Status shapes what becomes visible. SAS doctors may carry substantial clinical responsibility while holding less formal organisational power than colleagues whose titles are more readily associated with authority. A long-serving doctor may be treated as indispensable for service delivery but excluded from decisions about the service. Locally employed doctors, internationally qualified doctors and people new to NHS systems may have still less access to informal networks or may be uncertain about routes for challenge. These patterns require examination, not an assumption that every difference is discriminatory.

Protected characteristics, migration history, accent, gender, disability, working pattern, religion and caring responsibilities can interact with grade and informal power. The correct method is to ask what happened to whom, how comparable decisions were made, what explanation was given and whether a protected ground may be relevant. A single comparator is not always necessary or sufficient for legal analysis, and the handbook cannot decide a claim. It can help the reader preserve the facts from which an adviser or investigator can assess it.

Informal authority matters too. The person who controls the rota, meeting invitations or access to a senior leader can shape a career without holding a prominent title. A colleague may exclude someone through habit, preference or misunderstanding rather than a deliberate plan. Harm and the need for correction do not depend entirely on proving malicious intention. At the same time, accusing an individual of motive without evidence can harden the dispute and distract from an observable process failure.

Look for distribution. Who receives acting roles, teaching opportunities, study leave, useful feedback and sponsorship? Who is asked to cover gaps or perform emotional labour? Are criteria published and applied consistently? Aggregate patterns can reveal inequality that isolated anecdotes cannot. An individual doctor should not secretly collect personal information about colleagues to create an amateur statistical case. Use information already lawfully available, ask the organisation to review its own data and involve equality or workforce specialists where appropriate.

Power affects conversations. A junior or dependent colleague may agree in a meeting while feeling unable to object. A senior doctor may interpret silence as consent. Record whether the person had notice, information, representation and a genuine opportunity to respond. If Amina’s education opportunity was removed after a closed discussion, the organisation should be able to explain the criteria and decision-maker without requiring her to prove the private motive of everyone present.

Repeated patterns should be described with disciplined uncertainty. “Since raising the concern, I have been excluded on four documented occasions from meetings relevant to my agreed role” is a factual sequence. “The clinical lead is destroying my career” predicts intention and total consequence. Strong language may feel proportionate to distress but can make it harder for another person to identify the requested remedy. The record should remain firm, specific and open to evidence.

Bystanders hold evidence and power. A colleague who observed an event can record what they directly saw, challenge behaviour safely, confirm a factual meeting sequence or use their own reporting route. They should not coordinate accounts or promise a conclusion. Managers receiving several similar concerns should examine the pattern rather than treating each person as an isolated relationship problem. A culture becomes safer when speaking up is not left entirely to the person with least power.

This method does not ask doctors to tolerate harm until they have assembled a perfect case. Urgent safety, threats, sexual misconduct, discriminatory harassment or serious deterioration in health may require immediate formal support. Pattern analysis is for clarity, not delay.

## Immediate safety and wellbeing

Deal first with what cannot wait. If a patient or group of patients may face immediate serious risk, use the clinical escalation and incident routes available now. Ensure urgent care is provided within competence and authority, contact the responsible senior person and record the clinical or operational facts in the authorised system. The GMC expects doctors to act where they believe patient safety or dignity is, or may be, seriously compromised and to use appropriate local or external routes according to urgency and response.[37]

Do not make resolution of the employment dispute a precondition for controlling the safety risk. Amina’s concern about unallocated results needs an accountable interim control whether or not her later exclusion is connected. She asks who is checking the work today, how missed items will be identified and when the permanent process will be reviewed. The personal treatment can then be addressed through its own route, with cross-reference where the chronology matters.

Consider personal safety. Threats, stalking, violence, sexual assault or immediate risk may require security, police, safeguarding or emergency clinical help rather than an informal workplace conversation. Follow organisational emergency arrangements. Preserve relevant communications without circulating them widely. A manager should not pressure the person

to meet the alleged perpetrator alone as the first response to a serious allegation.

Workplace conflict can affect sleep, concentration, confidence and physical health. A doctor experiencing these effects should obtain healthcare in the ordinary way rather than attempting to be their own clinician. A GP, occupational health service or appropriate urgent service can assess health needs. The employer's staff support or employee assistance programme may offer additional help, but it is not a substitute for independent clinical care where that is needed.

Occupational health can advise on functional effects, work capacity, adjustments and a supported return. It does not decide the truth of a grievance. Keep clinical information proportionate to the employment question; managers ordinarily need functional advice rather than unrestricted health records. If disability may be relevant, obtain individual advice on reasonable adjustments and the applicable equality law. Do not wait for crisis before asking for temporary changes to reduce risk.

Professional support may come from a trusted colleague, SAS tutor or advocate, trade union, defence organisation, professional support service or mentor. Clarify the person's role and confidentiality boundary. A friend can help organise thoughts but may not provide independent legal advice. An organisational advocate may help navigate systems but may have duties to escalate safety information. Ask before disclosing sensitive material.

Create a same-day support plan: immediate patient control; immediate personal-safety action; health contact; professional or representative advice; a safe person for the next meeting; and the next review time. If distress is impairing safe practice, seek help and adjust duties through proper arrangements. Continuing without support to prove commitment can expose both doctor and patients to further risk.

Wellbeing support should not replace organisational action. Mindfulness, counselling or resilience training may help an individual cope, but they do not correct unsafe systems, harassment or unfair decisions. Ask separately what support the doctor needs and what control the employer must consider. The fact that someone accepts counselling does not mean they accept the behaviour or withdraw the concern.

Agree communication during acute distress. One named contact, scheduled updates and a plan for urgent matters can reduce repeated exposure to contested correspondence. The doctor may ask that complex instructions are confirmed in writing or that a representative attends meetings. These measures should remain proportionate and be reviewed. Complete withdrawal from communication may be unsafe if clinical

responsibilities continue, while constant unscheduled contact may worsen health.

If absence from work becomes necessary, maintain appropriate contact through sickness and employment procedures. Do not use sickness certification as evidence that the grievance is true or false. Plan how essential handover will occur without expecting the doctor to continue substantive work while unfit. Before returning, identify the working arrangements, unresolved risks and support needed for a safe transition.

## Building a factual record

A contemporaneous record helps memory, advice and fair investigation. It should not become a secret parallel personnel file containing unnecessary patient or colleague information. Use approved organisational systems for clinical incidents and formal reports. Keep a separate personal chronology only where lawful and necessary, with secure storage and minimal identifiers. Follow local information-governance advice if uncertain.

For each workplace event, record the date and time; setting; people present; words or actions as accurately as possible; relevant document or decision; immediate response; observable impact; follow-up; and current status. Separate direct observation from what another person reported. If wording is approximate, say so. Do not improve a quotation after several weeks or turn an inference into a fact.

Preserve original emails, messages and meeting papers in their authorised location. Do not alter them, forward large chains to a personal account or record conversations secretly without individual advice about legality, policy and consequences. If access may be lost during employment change, ask a representative how necessary records can be preserved properly. A screenshot without context may be less useful than the complete authorised record.

Patient information requires particular restraint. The safety report belongs in the clinical governance system. Amina's personal chronology can say "recurring unallocated-result risk reported through incident reference held by employer" rather than reproduce names, identifiers or clinical detail. If a representative needs information, establish the secure route and disclose only what is necessary. Employment frustration does not cancel duties of confidentiality.

Record your own responses as well as other people's actions. If you declined a meeting, missed a deadline or used intemperate language, include it. Explain relevant context without rewriting the history. A credible

chronology may reveal mistakes on several sides. Its purpose is to support a fair next decision, not to construct a flawless protagonist.

Group events by issue. One column might concern the patient-safety risk; another the education opportunity; another meeting access and communication. Link them through dates without assuming causation. This makes it easier to decide which remedy belongs to which route. The safety route may require a control and governance review. The employment route may require reasons, restoration of duties or a fair process. The wellbeing plan may need changes regardless of either outcome.

Write the requested outcome beside each event. “Please restore me to all meetings” may be too broad if the service structure has changed. “Please confirm the criteria for membership, why my agreed role no longer qualifies and how I will receive information required for that role” is testable. Possible outcomes include stopping behaviour, correcting a record, explaining a decision, restoring access, reviewing allocation criteria, protecting safety, arranging mediation or agreeing contact boundaries.

Check the record before sending it. Remove speculation presented as fact, unnecessary adjectives and unrelated historic disputes. Verify dates against source documents. Identify gaps rather than filling them from memory. Ask a representative to review the structure if the matter is serious. Once a written allegation is submitted, it may be disclosed within the process; do not assume it will remain known only to the first recipient.

Maintain document control. Give the chronology a date and version, keep later additions visibly dated and retain the source from which each significant statement came. If an error is found, correct it transparently rather than replacing the record silently. A short correction strengthens credibility. Multiple uncontrolled versions sent to different recipients can create apparent inconsistencies that obscure the underlying issue.

The workplace event record can use these fields:

Event: date, place, people and exact action or wording.

Source: email, meeting record, direct observation, policy or reported account.

Issue: safety, conduct, employment decision, equality, health or another category.

Impact: clinical, professional, employment or health effect that can be described.

Response: what I did, whom I told and what happened next.

Uncertainty: what I do not know, including motive or decision basis.

Outcome sought: the specific action or explanation now requested.

Storage: where the authorised record is held and any confidentiality restriction.

## Informal resolution

Informal resolution can correct a misunderstanding, set a boundary or restore a working relationship without a full formal process. It is an option, not a compulsory test of endurance. It may be unsuitable where there is immediate danger, serious alleged misconduct, a major power imbalance, repeated failed attempts, risk to evidence or a reasonable fear of direct contact.

Prepare the conversation around one or two observable issues. State the event, effect and request. Amina might say: “I was not invited to the last three pathway meetings, although the current role description still assigns me responsibility for the clinical standard. I could not contribute the evidence I hold and did not receive the decisions afterwards. Please confirm whether my remit has changed. If it has not, I need invitations and papers restored; if it has, I need the decision and revised responsibilities in writing.”

Choose the recipient who can act. That may be the colleague concerned, line manager, clinical lead or another manager where the usual line is implicated. Ask for a private meeting with enough notice. Consider representation or a support person under local policy. Agree a written summary afterwards. The objective is not to force an admission of bullying; it is to establish what happened and obtain a workable response.

Listen to the explanation and test it. A distribution-list error may explain one missed meeting, but not why a development opportunity was reallocated. A service redesign may legitimately change membership, but the organisation should then clarify responsibilities. Resolution can include apology, correction, agreed communication, mediation, restored opportunity or a monitored behavioural boundary. Make ownership and review date explicit.

Mediation is a facilitated process, not an investigation or determination of facts. It can help where parties want to repair a relationship and can participate safely. It may not be appropriate when the central need is a formal finding, urgent protective action or resolution of a legal question. Ask what confidentiality applies, what can be recorded and what happens if no agreement is reached.

Keep informal steps time-limited. If agreed action does not happen, or the behaviour continues, review whether to use the formal policy. Repeating the same private conversation while the position deteriorates is not

proportionate. Equally, do not threaten multiple processes in every email. State the issue, route and next step calmly.

An informal boundary can be exact: “Please give feedback about my work in a private scheduled meeting, with the examples and expected standard identified. Do not raise personal criticism in front of the clinical team.” This does not prevent legitimate management. It specifies a professional way to conduct it. If the colleague disputes the account, ask whether they can nevertheless agree the future communication standard.

A manager receiving an informal concern should acknowledge it, clarify what the person wants, check immediate risk and avoid taking sides before facts are understood. They can separate immediate protective arrangements from final findings. If the allegation is serious or policy requires formal action, the manager should explain why it cannot remain informal. Silence or an instruction to “sort it out between yourselves” is not a neutral response when there is a significant power imbalance.

Plan the meeting on one page: issue; two key examples; effect on work; policy or role context; outcome sought; acceptable alternatives; question for the recipient; and review date. Decide in advance what would end the meeting—for example threats, shouting or pressure to disclose confidential clinical information. Afterward, send a concise factual note, invite correction and retain it in the appropriate place.

Informal agreement needs follow-through. If meeting invitations are restored, check that papers and decision information also arrive. If an apology is offered, agree the behaviour that will change. If development access is reconsidered, use published criteria rather than a private favour. Review the arrangement after a defined period and close the issue in writing if it has genuinely resolved.

## Formal employment routes

A formal grievance normally asks the employer to examine an employment concern under its policy. A dignity-at-work or respect policy may provide a more specific route for alleged bullying or harassment. Equality, disciplinary, capability, speaking-up and patient-safety procedures may operate alongside or separately. Obtain the current local policies and identify the correct recipient, stages, representation rights and appeal route rather than relying on a former employer’s process.

In Great Britain, the Acas Code sets principles for handling disciplinary and grievance matters, including written concerns, meetings, accompaniment and appeal; tribunals may take unreasonable failure to follow the Code into account in relevant cases.[117] Northern Ireland has

separate employment institutions and Labour Relations Agency guidance and conciliation arrangements.[118] These frameworks do not decide whether a grievance will succeed. They provide process and advice routes.

A formal submission should identify the relevant events, sources, impact, prior steps and requested outcomes. Attach a focused chronology and key documents, not an unfiltered archive. State where safety information is held. If discrimination, whistleblowing detriment or another legal issue may arise, use qualified wording and seek specialist advice. The investigator should determine disputed facts; the complainant does not need to pre-judge every legal category.

Internal procedures and legal time limits are different clocks. Starting a grievance, investigation or appeal does not necessarily stop a tribunal limitation period. Limits vary by claim, jurisdiction and circumstance, and 2026 changes make remembered figures particularly unsafe. Obtain prompt advice from Acas and a union or employment adviser in Great Britain, or the Labour Relations Agency and an appropriate adviser in Northern Ireland. Do not wait for the internal outcome before checking time.[45]

Representation matters. A trade union can advise on strategy, attend eligible meetings and help distinguish achievable remedies from allegations requiring another route. Defence organisations may advise where professional regulation, clinical responsibility or medicolegal risk is engaged, but ordinary employment representation depends on membership and service terms. Ask early which organisation covers which issue. Do not send confidential records until the secure and authorised method is agreed.

The employer should manage conflicts of interest. If the complaint concerns the person who would normally appoint the investigator, ask who will make that decision independently. If several processes overlap, ask for a written explanation of scope: who is investigating conduct, who owns the safety action and how information will be shared. Parallel processes may be necessary, but duplication and contradictory instructions should be avoided.

Confidentiality cannot be absolute. Fair investigation may require allegations and evidence to be disclosed to the person complained about and to relevant decision-makers. The organisation should limit information to those who need it and explain the process. Anonymous evidence may be harder to test. Before submission, ask what can be kept confidential, what must be shared and how sensitive patient or health information will be protected.

Formal process can itself create strain. Agree a contact person, expected updates, meeting arrangements and temporary working measures. A neutral change in reporting line, separation at particular meetings or adjusted

communication may protect the process without presuming either party's case. Record that interim arrangements are not a final finding.

Appeal should address a defined problem: factual error, procedural defect, new evidence or unreasonable conclusion within the policy's terms. It is not improved by repeating the entire grievance unchanged. Check the deadline immediately and obtain representation. If the desired remedy is outside the decision-maker's authority, ask who can consider it.

Maintain ordinary procedural fairness when roles reverse. SAS doctors in management may receive a complaint about their own conduct or may be asked to investigate another colleague. They should preserve evidence, declare conflicts, avoid retaliation and keep the safety response separate from personal defensiveness. An investigator needs an agreed scope, competent support and enough time. The person complained about should know the substance of the allegation and have a fair opportunity to respond, subject to lawful confidentiality and protective measures.

Outcome letters should distinguish findings, reasons, recommendations and implementation. "No formal bullying finding" does not necessarily mean every behaviour was appropriate. The organisation may still identify communication, governance or allocation problems requiring action. Conversely, an upheld concern does not determine every requested remedy. Ask who owns each action and how completion will be evidenced.

Settlement discussions, confidentiality clauses, resignation and external proceedings carry consequences beyond a generic handbook. Obtain independent union or legal advice before agreeing terms. A promise that a process will be "off the record" may not have the legal effect assumed. Do not sign quickly merely to end distress, and do not reject a proposal without understanding it. The aim is informed choice, not escalation for its own sake.

## Speaking up about patient safety

Speaking up is broader than a personal grievance. It includes raising information about risk, wrongdoing or barriers to safe care so that the organisation can respond. Whistleblowing is a legal category with specific conditions; not every concern or complaint is a protected disclosure. The safest practical starting point is to state the information, reasonable basis, affected public interest or patient risk, and the action needed, then use an appropriate route and obtain advice where legal protection matters.

The GMC's guidance supports raising concerns through local systems where possible, escalating when the response is inadequate and using suitable external routes in defined circumstances. Doctors should keep a record of the concern and steps taken.[37] It does not guarantee that a

particular communication is legally protected or that confidentiality can always be maintained. A safety report should remain professionally worded, evidenced and proportionate even when relationships are strained.

The four nations use different organisational frameworks. In England, NHS England's national speak-up policy remains a minimum framework for local policies. From 1 July 2026, after closure of the National Guardian's Office, NHS England took on specified national support and policy functions, while healthcare organisations became responsible for publishing accurate local Guardian contact arrangements.[119] Readers should therefore use their employer's current Freedom to Speak Up policy and contact details, not an old national directory.

In Wales, *Speaking Up Safely* provides the NHS Wales framework and is implemented through organisational procedures and contacts.[51] In Scotland, the Independent National Whistleblowing Officer's National Whistleblowing Standards provide the NHS process and external review framework.[52] In Northern Ireland, HSC organisations use the Department of Health whistleblowing framework and their current local policy; alternative internal contacts may be available where the line manager is implicated.[53] Titles, stages and response arrangements should not be transferred between nations.

Choose the route by function. An incident system can record and manage a clinical event. A line manager or clinical governance lead may address an operational risk. A Freedom to Speak Up Guardian or equivalent can help a worker navigate concerns and barriers. A regulator or other prescribed body has a defined remit. One report may need linked routes, but sending the same unstructured allegation to many recipients can compromise confidentiality and confuse ownership.

External disclosure requires care. In Great Britain, whistleblowing law protects certain workers from detriment or dismissal when statutory conditions are met, including reasonable belief about specified wrongdoing and public interest; wider external disclosures have additional conditions.[120] Northern Ireland has a distinct legal framework and advice route.[55] Social media, press or a body without the relevant remit should not be treated as an equivalent escalation. Seek legal or representative advice before disclosure beyond normal authorised routes unless immediate circumstances require emergency action.

Amina's safety report identifies the handover process, examples recorded in the governance system, the current control gap and a requested accountable response. She separately records her exclusion and lost opportunity under the employment route. The two documents cross-

reference the chronology but do not make correction of patient risk conditional on proving retaliation. This structure helps the employer protect patients while examining the treatment of the person who spoke up.

Ask for feedback that can properly be provided: acknowledgement, named owner, immediate control, investigation or review route, expected update and how learning will be shared. Some information about other staff cannot be disclosed. Lack of a detailed disciplinary update does not necessarily mean that no action occurred, but the organisation should still explain how the safety concern is being managed within confidentiality limits.

Anonymous and confidential raising are not identical. An anonymous report does not identify the reporter, which may limit questions, evidence checking and feedback. A confidential report identifies the person to a restricted recipient with an expectation that information will be limited, but identity may still need to be disclosed in some circumstances. Ask the local route what it can realistically protect before choosing. Keep copies of what was submitted and any acknowledgement.

A speaking-up concern should not be dismissed because the feared event has not yet harmed a patient. Reasonable concern may relate to danger that is likely to occur, a recurring near miss or concealment of information. Equally, speculation unsupported by identifiable facts is harder to assess. Explain the mechanism of possible harm, the information on which the belief rests and the proportionate control requested.

If the response is absent or the risk persists, escalate according to urgency and the applicable framework. State what was raised, when, to whom, the response and why the remaining risk matters. Avoid adding unrelated employment history to a safety escalation unless it explains obstruction or possible detriment. A concise, traceable escalation is harder to dismiss as a general conflict.

## Retaliation recovery and continuing work

Adverse treatment after a concern may be deliberate retaliation, an unrelated decision or a mixture of strained relationships and flawed process. Do not wait for motive to be proved before addressing the working consequences. Ask for transparent decisions, access to information, safe duties, communication boundaries and a review of opportunities. Continue documenting new events without turning every ordinary disagreement into part of the case.

Amina and her representative use a route selector. Patient risk remains with the governance lead and is tracked to a named control. Her meeting

exclusion and development opportunity enter a formal employment review because informal requests did not resolve them. She obtains advice on whether equality or whistleblowing law may be engaged. Occupational health advises on temporary meeting arrangements after her sleep and concentration deteriorate. Each route has a defined question and owner.

Recovery is not the same as winning a finding. The process may substantiate all, some or none of the allegations. The doctor may still need restoration of role clarity, a repaired working relationship, health support and a decision about future work. Agree how outcomes will be implemented, who will monitor them and when the arrangements are reviewed. An apology without changed access or behaviour may be incomplete; a policy change without support for the people involved may also fail.

Protect professional practice. Keep clinical documentation, appraisal, CPD and job-plan evidence current. Obtain appropriate supervision if confidence has been affected. Do not use patient interactions or learner relationships to process the dispute. If allegations raise regulatory risk, contact the defence organisation or other professional adviser promptly and respond through the proper process. A workplace grievance should not become the only record of the doctor's professional life.

Consider repair where it is safe and genuine. A facilitated meeting may clarify future communication, but it should not require Amina to retract a substantiated concern or accept blame as a condition of ordinary inclusion. Agreements should specify behaviours and processes: papers circulated by a deadline, invitations based on role, no one-to-one meetings for a period, or decisions confirmed in writing. Review whether the arrangement works.

If staying, identify the minimum conditions for sustainable work: safe clinical system, defined remit, respectful communication, fair access to opportunity, effective escalation and health support. Ask which conditions are within the employer's control and by when. If moving, preserve authorised evidence, obtain references appropriately, complete handover and seek advice before resignation where rights, pension, sickness, notice or an unresolved process may be affected. Departure can be a rational choice, but it should not be made in a moment of acute distress without understanding consequences.

The support plan should name people, not merely services. Record the representative, health professional, trusted colleague, responsible manager and governance contact; what each may do; what information may be shared; and the next review. Avoid depending on one supporter. If that person changes role or becomes conflicted, the plan should still function.

Use a final route check:

Safety: Is anyone at immediate risk, what control is in place and who owns it?

Behaviour: What specific acts or words need to stop or be examined?

Employment: Which decision, duty, opportunity or process requires explanation or remedy?

Equality: Could a protected ground or protected act be relevant, and has specialist advice been obtained?

Speaking up: Does the information concern public-interest wrongdoing or patient safety, and what national and local route applies?

Health: What clinical help, occupational advice or adjustment is needed now?

Evidence: Are the chronology and source records factual, proportionate and secure?

Time: Which internal and external deadlines need immediate advice?

Support: Who can represent, advise and attend the next meeting?

Outcome: What concrete action is requested, from whom, and when will it be reviewed?

Amina's position becomes clearer even before every dispute is resolved. She can show that the safety concern was legitimate and routed correctly, that the employment decisions require an evidenced explanation, and that her health and professional work need active protection. She has not had to prove another person's inner motive to request a safe system and a fair process.

The reader's next step is similarly bounded. Name the issue without overclaiming, control anything urgent, preserve a lawful factual record, select the route that can provide the needed decision and obtain advice before time or disclosure choices narrow the options. Dignity is not restored by better paperwork alone, but clear evidence, proportionate process and sustained support give both the doctor and the organisation a fairer chance of acting well.

Chapter 21

# NHS pensions and long term career choices

## Why the NHS pension is different

Michael, the composite Associate Specialist introduced earlier in the handbook, is considering a change in the intensity of his work. He has benefits associated with the 1995 Section and the 2015 Scheme, a long employment record, two programmed activities of on-call work and a recent increase in pensionable salary. His annual statement shows several figures, while a separate Pension Savings Statement suggests that pension growth may need attention for tax purposes. A colleague tells him to take the whole pension immediately; another says he should opt out before the next pay award. Neither has seen his records. Both have turned a question requiring evidence into a recommendation.

The NHS Pension Scheme is principally a defined-benefit arrangement. The benefit is worked out under the rules of the relevant section or scheme; it is not simply the balance of the doctor's own contributions invested in an individual pot. Employee contributions buy membership and contribute to the cost of providing the promised benefits. Employer contributions help fund the scheme, but they are not normally a personal account that can be withdrawn. This distinction explains why adding up deductions on payslips does not reveal the value of an NHS pension and why an increase in contributions does not translate directly into the same increase in retirement income. [121][122]

Three records must be kept conceptually separate. The benefit record shows service, pensionable pay or annual career-average pension and the sections in which rights have been built. The retirement estimate applies scheme rules and actuarial factors to a proposed date and benefit choice. The pension-tax record values growth during a tax year under HMRC rules. A figure from one record cannot be substituted safely for a figure required by another. A retirement estimate may be accurate for its stated assumptions but cannot by itself establish whether an annual-allowance charge arises.

The scheme is valuable partly because it combines an income for life with provisions that may include ill-health and family benefits. Those features also make comparisons with a personal investment fund misleading. A commercial transfer value, a notional capital value used for tax and the

annual pension payable are answers to different questions. None should be described casually as 'the pot'. Where this chapter uses a value, it identifies the purpose for which that value is produced.

Pension decisions are therefore career decisions as well as financial ones. A reduction in hours may alter pay, duties and pensionable earnings. Partial retirement requires an employment arrangement as well as a benefit claim. A move between UK nations may change the scheme administrator and create a transfer question. Ill health may make the timing of an application important before employment ends. The safe method is to establish the facts, obtain official figures, understand the employment consequences and then seek individual advice where judgement remains.

This chapter provides a map, not personal financial advice. It does not tell Michael, or any reader, whether to retire, opt out, commute pension for cash, select legacy or 2015 remedy benefits, or use scheme pays. Those decisions depend on age, health, tax, family circumstances, other pensions, protections, earnings and preferences. The purpose is to make the consultation with administrators, employers and regulated advisers more productive.

There is also a difference between benefit security and personal suitability. A defined-benefit promise removes much of the investment and longevity risk that an individual would otherwise bear, but a member still has decisions about timing, work and tax. Someone with short service, substantial other provision or immediate health needs may weigh the same option differently from a colleague with no other income. Describing the scheme as valuable is compatible with refusing to tell an unknown reader what to do.

Language is an early safety tool. Say contribution rate when discussing deductions, accrual rate when describing how pension is earned, revaluation when an earned amount is adjusted under scheme rules, and actuarial reduction when benefits are paid early. Say forecast when assumptions remain and entitlement when the scheme has confirmed a benefit. These distinctions stop ordinary words such as value, growth and return carrying an investment meaning they do not have in this context.

A quick diagnostic helps when advice sounds certain. Ask which section is being discussed, what benefit date is assumed, which statement supplies the figure, which tax year applies and whether the speaker knows about other pensions. If those questions cannot be answered, treat the statement as a prompt to investigate rather than a conclusion. Pension folklore is often based on a real rule applied to the wrong person, scheme or date.

## The 1995 2008 and 2015 arrangements

A long-serving SAS doctor may have rights in more than one arrangement. The 1995 and 2008 Sections are legacy final-salary designs, while the 2015 Scheme is a career-average revalued earnings scheme. From 1 April 2022, active members build new NHS pension benefits in the 2015 Scheme, subject to the effect of the public-service pensions remedy on service during the remedy period. Earlier rights have not simply disappeared. They retain their own rules and may remain linked to later pay in ways that need to be checked against the member's record. [121][122]

For an employed officer in the 1995 Section, the basic annual pension is ordinarily built at one eightieth of the relevant pensionable pay for each year of pensionable membership, with an automatic retirement lump sum normally equal to three times the pension. The usual normal pension age is 60, although special class, mental-health-officer status and individual history can alter the position. The 2008 Section ordinarily builds pension at one sixtieth of reckonable pay for each year and has a normal pension age of 65. It does not generally provide an automatic lump sum, although pension may be exchanged for cash within scheme and tax limits. These descriptions concern ordinary officer membership; practitioner calculations and protected statuses require their own guidance. [121]

The 2015 Scheme adds a slice of pension for each scheme year, ordinarily one fifty-fourth of pensionable earnings for that year. While a member remains active, accumulated slices are revalued in accordance with scheme rules, using the Treasury Order plus 1.5 percentage points. Its normal pension age is the member's State Pension age, or 65 if later. It generally has no automatic lump sum, but a member may usually give up part of pension to provide a lump sum within the applicable limits. Each slice is based on the pay for its own year, which is why the label career average is more accurate than final salary. [122]

The formulas explain, but do not produce, Michael's answer. His 1995 rights may depend on pensionable membership and final pensionable pay calculations. His 2015 rights consist of annual slices and revaluation. Benefits drawn before the normal pension age that applies to them will ordinarily be reduced because they are expected to be paid earlier and for longer. Some benefits taken after normal pension age may receive late-retirement increases; the treatment is section-specific. A single retirement date can therefore affect different parts of the same person's pension differently.

Lump-sum language also needs discipline. An automatic 1995 Section lump sum is part of the section's basic design. Commutation is the exchange

of some annual pension for additional cash. A pension commencement lump sum is a tax category. Partial retirement may draw a proportion of benefits, including the associated automatic lump sum where relevant. These concepts overlap in practice but are not synonyms. Before choosing cash, ask which benefits are being exchanged, the commutation terms, the effect on survivor benefits if any, the tax-free allowance available and the permanent reduction in annual income.

The normal pension age is not a compulsory retirement age. It is the age at which the relevant pension can ordinarily be paid without an early-payment reduction. Employment law, capability, health, service requirements and an individual's intentions are separate matters. Equally, reaching a normal pension age does not make taking benefits automatically optimal. Continuing work can affect pay, tax, later accrual and the treatment of different scheme sections.

Create a personal scheme-membership timeline before interpreting any projection. Record each NHS employment, dates, nation, full- or part-time status, known section or scheme, breaks, transfers, opt-outs, purchased benefits and previous benefit events. Mark entries as confirmed, inferred or disputed. A confident memory that 'I have always been in the 1995 scheme' may overlook a transition, a break or the remedy. The official record should decide the factual starting point.

The final-salary link deserves particular attention. A member with legacy rights who moved into the 2015 Scheme may still have final-salary benefits calculated by reference to later pensionable pay when the statutory conditions are met. A break, transfer, change of employment category or remedy position may affect how the link operates. It is therefore unsafe to freeze a legacy estimate in the year active accrual changed and assume it cannot move. Ask the administrator what pay and service the estimate uses.

Protection is another word with several meanings. It may refer to transitional protection during reform, a protected minimum pension age, lifetime-allowance protection, special class status or protection of pay in a legacy section. One does not establish another. Write the exact protection on the timeline with its source document. If the record simply says protected, it is not yet precise enough to support a decision.

Additional pension, added years, early-retirement-reduction buy-out and money-purchase additional voluntary contributions also work differently. The first group may add defined benefits or alter a reduction; a money-purchase AVC builds a separate invested fund. Record the provider, contract dates, contribution, benefit and dependant cover. A forecast that omits an

additional arrangement should not be used to compare retirement dates until its treatment is clear.

## Which administrator and records apply

NHS Business Services Authority administers the NHS Pension Schemes for England and Wales. The Scottish Public Pensions Agency administers NHS pensions in Scotland. HSC Pension Service administers the Health and Social Care pension arrangements in Northern Ireland. These schemes share much history and many design features, but they are legally and administratively distinct. A form, calculator, deadline or contact route from one administrator should not be assumed to govern employment in another nation. [12][13][123]

The correct administrator follows the scheme in which the service was pensionable, not the doctor's home address or present employer alone. Someone who worked in Wales and later Scotland may hold benefits under different administrations. Moving does not necessarily combine them automatically. The member should ask whether benefits remain separate, whether a transfer is possible, what time limit and terms apply, and what would happen to any final-salary link or protected status. A transfer is a consequential financial decision; obtaining a quotation is information gathering, not a direction to proceed.

For England and Wales, the online Total Reward Statement or Annual Benefit Statement may provide annual benefit information, while My NHS Pension increasingly supports access to records and estimates. Scotland uses its own member portal and statements. Northern Ireland has its own HSC Pension Service records and forms. Access arrangements change, so the durable instruction is to begin at the administrator's official member hub and retain the dated statement actually used for a decision.

Payroll and the scheme administrator answer different parts of an apparent error. Payroll holds employment pay, contribution and submission information. The administrator uses data supplied by employers to maintain the benefit record. If pensionable service is absent, first identify the employer, dates and payroll reference. Ask payroll or the pensions officer what was submitted and ask the administrator what is recorded. Sending a general complaint to one side can produce two correct but incomplete answers.

The employing organisation remains important after a move. It may hold historic forms, contribution records and the details transmitted to the scheme. Obtain written contact details before an account closes. Do not send national-insurance numbers, statements or identity documents through an

insecure route merely because the enquiry is urgent. Use the administrator's authenticated portal or specified secure process.

An annual statement is not a guarantee that every element is correct, nor is an online calculator a substitute for an official estimate in a complex case. NHSBSA specifically identifies categories for which its partial-retirement calculator may not be suitable, including some members affected by remedy, members with multiple part-time employments, practitioner history, transfers, certain breaks and additional-benefit arrangements. [130] The correct response to complexity is not to abandon planning; it is to request the right kind of estimate.

When recording advice, name its status. Information from the administrator explains records and scheme administration. Tax advice should come from a suitably qualified tax adviser. A recommendation about investments or retirement choices may require a regulated financial adviser who understands NHS pensions. Trade unions and specialist medical-finance educators can help explain issues and prepare questions, but their material should not replace the current scheme rules or HMRC position. Medics' Money and BMA pension guidance are useful in this interpretive role; operative figures in this chapter come from primary sources. [134] [135]

Build an administrator map for mixed service. One row should identify each scheme, administrator, membership number, online account, employment periods, latest statement, query route and nominated contact. A second row should identify each employer payroll and pensions office. This prevents correspondence about Scottish service being sent to NHSBSA merely because the member now works in Wales, and it makes explicit when a former employer still holds the evidence required to correct a national record.

Verify the identity of anyone offering help. Official administrators do not become financial advisers merely because they provide an estimate, while a regulated adviser does not gain authority to alter the scheme record. Check the Financial Conduct Authority register for regulated advice where applicable, understand whether the adviser is independent or restricted, and ask about NHS pension experience, charging and conflicts. Do not send an entire financial archive before the scope and security of the engagement are agreed.

## Pensionable pay and multiple employments

Pensionable pay is the pay recognised under the applicable scheme and employment rules. It is not necessarily gross taxable pay. In the NHSBSA

1995/2008 officer guide, salary, wages and fees may be pensionable, while bonuses, expenses, overtime above whole-time equivalent hours and non-consolidated awards are excluded in the circumstances described. The precise result depends on the payment and the member category. The presence of income tax or national insurance on a payment does not prove that it is pensionable. [121]

For SAS doctors, the difficult cases often involve recurring additional work. A programmed activity incorporated into a substantive job plan may be treated differently from ad hoc overtime or bank work. On-call availability supplements, recruitment or retention payments, waiting-list work and management responsibilities need to be checked rather than grouped together. The payslip code is evidence of payroll treatment, but an unfamiliar code should prompt confirmation of the underlying rule.

Part-time service creates another common misunderstanding. In legacy final-salary arrangements, pensionable membership and the pay figure used in the benefit calculation may be adjusted in different ways. In the 2015 career-average design, pensionable earnings in the year determine the slice earned. A reduction in sessions may therefore affect legacy and 2015 benefits through different mechanisms. The doctor should not multiply a whole-time estimate by an intuitive percentage and assume the result is authoritative.

Concurrent NHS employments should be recorded separately. Michael's substantive contract and an additional regular bank engagement may appear on different payrolls even within one organisation. One may be pensionable and the other not, or each may create a separate pension record. If total hours exceed whole-time employment, the treatment of additional hours requires specific confirmation. Check the contribution deduction, pensionable-pay-to-date figure and employer pension reference for each post rather than assuming that one correct payslip proves the whole record.

A move between employers creates risk at the join. Ending one assignment and starting another on the same date does not guarantee seamless data. Changes in payroll provider, employee number or pension administrator can create duplicated or missing periods. Keep the final payslip and P60 where applicable, the new starter statement, contractual hours and the first three payslips from the new post. Compare the cumulative pensionable pay with the expected position.

Unpaid leave, sick leave, family leave and career breaks can affect contributions and credited service under specific provisions. Do not reconstruct the effect from absence dates alone. Record the type of absence, pay received, contribution treatment and any election or correspondence. A

period marked zero pay may be correct, incomplete or awaiting a later adjustment. The question is what the governing rule and actual submission require.

Back pay can have effects beyond the month in which it arrives. It may correct pensionable pay for an earlier period and may influence pension input calculations. A national pay award paid late, successful regrading or payroll correction can produce a larger-than-usual change. Preserve the award letter, effective date, payment date, allocation across tax years if supplied and revised pension record. Tax treatment follows tax rules, while pension growth may be attributed under scheme calculations; the two timelines should not be collapsed.

The practical pensionable-pay audit has seven fields: employment; period; contracted work; gross pay; pensionable pay; employee contribution; and administrator record. Add a note for each discrepancy stating who owns the next check and when a response is due. Do not put patient information or unrelated employment disputes into this schedule. Its purpose is narrow factual reconciliation.

Opting out should never be suggested as an automatic response to a high contribution deduction or possible tax charge. It affects future accrual and may affect valuable death-in-service and ill-health protections. Rejoining and automatic-enrolment rules may also matter. A doctor considering it needs current official information and individual advice that weighs pension tax against the benefits being forgone. The same caution applies to reducing pensionable work solely on an unverified estimate.

Pay protection may be relevant where a legacy member's pensionable pay falls through no fault of their own or where they step down to a less demanding role, but routes, eligibility and deadlines are section-specific. The NHSBSA legacy guide, for example, describes separate protections and short application periods in some circumstances. [121] A doctor contemplating a later-career reduction should ask about protection before the pay change, not months afterwards. Protection of legacy pay does not preserve current salary, prevent reduced 2015 accrual or make the employment change reversible.

When a payment's status is unclear, frame the enquiry precisely: identify the contract, payment label, period, hours, whether it is consolidated, and how payroll has treated it. Ask which scheme rule supports that treatment and whether corrected pension submissions will follow. This is more effective than asking whether 'my extras count'. Retain the reply with the relevant payslips, because the same label may be used for a different payment after a contract change.

## Annual statement and record reconciliation

Start the annual record check with a dated pack. Save the current benefit statement, relevant payslips, P60, employment-change letters, previous statement and any Pension Savings Statement. Record the date downloaded because online figures can be revised after employer updates, remedy work or data correction. A later figure that differs is not necessarily an error, but the change needs an explanation before a major decision.

First confirm identity and service. Check name, date of birth, national-insurance number through a secure route, employer names, employment dates, breaks and membership category. Next check working pattern. A full-time label against a part-time period, or an omitted concurrent post, can distort the record. Then compare pensionable pay with payroll, bearing in mind that gross pay is not the comparator.

Next inspect scheme allocation. Identify the 1995, 2008 and 2015 elements and whether remedy has changed the presentation. If a statement labels service in a way you do not understand, ask for clarification rather than editing your own timeline to match it. Record any special class, mental-health-officer, transferred-in, added-years, additional-pension or early-retirement-reduction-buy-out entries. Their absence may be significant even when the headline forecast looks plausible.

Then compare successive statements. Look for unexplained disappearance of service, large changes in pensionable pay, altered normal pension ages or a sudden change in lump sum. Some differences will follow revaluation, corrected records or remedy. The useful enquiry states the previous figure, current figure, relevant period and document dates. 'My pension has gone down' gives the administrator much less to investigate.

For each discrepancy, maintain a correction log: date identified; precise issue; documents supplied; employer or administrator contacted; reference number; response; residual question; and next review date. Keep factual pension correspondence separately from broader grievance material. If the issue arose during a contested pay decision, the pay dispute and the pension-record correction may need parallel action through different routes.

NHSBSA explains that employer pay and membership information is necessary to produce Pension Savings Statements and that missing or late data can prevent timely calculations. [127] This means absence of a statement is not evidence that no annual-allowance issue exists. If circumstances suggest material growth but the statement is missing, check the official criteria and contact the administrator and employer early.

An official retirement estimate should specify the proposed date, benefits included, pension and lump sum choices assumed, early or late factors and

whether remedy choices are illustrated. Read the qualifications. If the estimate excludes a concurrent employment or assumes no future pay change, it cannot answer a question that depends on that employment or change. Ask for a revised estimate when the decision has materially different facts.

The annual pension record check concludes with three statuses. Confirmed means the evidence agrees. Query raised means a specific question has an owner and date. Advice required means the records may be correct but a choice needs individual analysis. Keeping these statuses separate prevents a financial adviser being asked to repair payroll and prevents payroll being asked which retirement option is best.

Carry the reconciliation beyond annual pension. Check whether a stated lump sum is automatic or assumes commutation, whether the estimate has applied an early or late factor, and whether survivor benefits are shown under the correct relationship status. If an estimate includes a remedy option, confirm which column is legacy and which 2015. A rounded online forecast may be sufficient for early orientation but not for choosing a benefit date.

Use a two-person verification for high-consequence data where possible. The member checks the chronology and personal documents; the administrator confirms the scheme record. An adviser may then check how the official figures have been used. This division does not guarantee correctness, but it reduces the risk of a beautifully calculated answer based on a missing employment. Where an adviser identifies a suspected record error, return it to payroll or the administrator for formal correction.

Set an annual calendar point after statements are normally refreshed, and a transition-point review whenever employment, pay, nation, hours or family circumstances change. The annual review maintains the record. The transition review asks whether an estimate, protection application or tax calculation is needed before action. These are different levels of work; not every annual check requires paid advice.

## McCloud remedy

The public-service pensions remedy responds to unlawful age discrimination associated with the 2015 reforms. For affected NHS members, the remedy period runs from 1 April 2015 to 31 March 2022. Under rollback, relevant service for that period was moved back to the applicable legacy 1995/2008 arrangement, with a choice between legacy and reformed 2015 benefits for the remedy period generally made when benefits become payable. NHSBSA supplies information through a Remediable Service Statement to support that choice. [124]

Not every member is affected, and being employed during those dates is not the only test. Eligibility depends on the statutory conditions and service history. A doctor should use the relevant administrator's remedy checker or guidance and avoid inferring entitlement from a colleague of similar age. Scotland and Northern Ireland operate the remedy through their own schemes and communications, even though the central problem and remedy-period dates are shared.

Rollback is an administrative reclassification, not the final personal choice. Until the choice point, statements may show legacy benefits for the remedy period. At retirement or another relevant benefit event, the member ordinarily receives comparative information and chooses the form of benefits for that period. The alternatives can differ in normal pension age, accrual, revaluation, lump sum and dependant benefits. Which produces a higher pension at one date may not be the better fit at another date or after considering tax and family circumstances.

Michael should therefore resist treating the largest annual pension shown in one column as the answer. He needs to establish the proposed retirement event, which sections are being drawn, the early-retirement effects, automatic or optional lump sums, the effect of final-salary links, survivor benefits, annual-allowance consequences and how much remedy service remains undrawn after partial retirement. A regulated adviser can then analyse choices using official figures rather than reconstructing benefits from general tables.

The remedy can alter pension-tax history because pension input for past tax years may change when service is rolled back or a remedy choice is implemented. Administrators provide remedy-related Pension Savings Statements where applicable, and HMRC has specific processes for affected years. [124][125] A member should not simply replace one figure in an old self-assessment return or assume that every revision creates additional tax. Identify the affected year, the revised statement, previous charge, scheme-pays election and current HMRC route.

A Remediable Service Statement needs its own check. Confirm the service period, legacy section, pay, membership type and benefits presented. Ask whether the statement is provisional, whether any employment remains missing and when a choice is required. If retirement is approaching before a corrected statement will arrive, obtain written instructions from the administrator and consider specialist advice. An urgent choice based on a known data error is not made safer by a short deadline.

Contingent decisions are decisions a member says they would have made differently but for the discrimination, such as an opt-out or additional-

benefit decision. Administrators publish criteria and evidence requirements. The existence of a route does not mean every retrospective preference will qualify. Preserve contemporaneous records, explain the claimed decision and follow the administrator's process. Avoid creating retrospective documents that appear to have been made at the time.

Partial retirement adds another layer. The percentage drawn before a final remedy choice may affect later adjustment or potential overpayment. NHSBSA and SPPA provide calculators or specific estimate routes, with warnings for complex cases. [130][131] Michael's mixed service and remedy position justify official personalised figures; a colleague's percentage does not.

The remedy checklist is short but consequential: confirm eligibility; reconcile remedy-period service; obtain the current statement; identify when choice occurs; compare benefits at the intended date; consider dependants and lump sums; obtain revised tax records; review any previous scheme-pays election; and seek advice before an irreversible election. Record the source version and date. Remedy administration continues to evolve, so recheck the current administrator and HMRC material immediately before taking action.

Remedy choice is sometimes described as choosing the 'better scheme'. That phrase conceals the actual comparison. Legacy benefits may have an earlier normal pension age and automatic lump sum; 2015 benefits may have different accrual and revaluation. The value changes with retirement date and personal priorities. Ask for the same proposed benefit date and work assumptions in each illustration so that differences arise from the remedy option rather than inconsistent inputs.

For someone already retired, implementation may involve arrears or recovery, interest, altered tax and changes to dependant benefits. The administrator should explain the figures and payment timetable. A member who disputes data should identify the specific service or pay issue while complying with any response date. If recovery would cause difficulty, raise this promptly through the stated route rather than assuming the amount can simply be ignored.

For someone approaching retirement, late delivery of an RSS can compress decision time. Keep evidence of requests and anticipated retirement dates. Ask whether a provisional estimate is appropriate, how any later adjustment will be handled, and whether an election can be amended under the operative remedy provisions. The answer must come from the current administrator process; this chapter cannot promise flexibility.

## Annual allowance

The annual allowance limits tax-relieved pension saving in a tax year. For 2026–27 the standard annual allowance is £60,000. This is a UK tax figure, not an NHS employment allowance, and it includes pension saving across registered schemes. Unused allowance from the previous three tax years may sometimes be carried forward, subject to the statutory conditions. [125] [126] Every figure in this paragraph is dated to the 2026–27 tax year and must be refreshed if the book is used later.

In a defined-benefit scheme, pension input is not the contributions deducted from salary. Broadly, tax rules compare the capitalised value of accrued benefits at the opening and closing of the pension-input period after applying the prescribed adjustments. The administrator performs scheme calculations and issues a Pension Savings Statement where required or requested. This is why a doctor cannot decide that the allowance has been exceeded merely because employee and employer contributions appear large.

The pension input amount can rise sharply after a promotion, regrading, pay correction, back pay or restoration of a final-salary link. A change does not have to place extra cash into an account. It changes the defined benefit promised under the rules. Inflation adjustments and scheme-specific calculations also matter. Michael's recent salary increase and mixed benefits create a reason to obtain the calculation, not proof of a charge.

The first document is the Pension Savings Statement for every relevant NHS arrangement. A doctor with private or other occupational pensions also needs the input information from those schemes. Add the figures by tax year, then assess the available annual allowance, any taper and any eligible carry forward. Do not use current-year thresholds retrospectively; the standard allowance was £40,000 for several earlier tax years and became £60,000 from 2023–24. [125]

Carry forward is not a separate cash reserve shown on the NHS statement. HMRC rules generally look to unused annual allowance from the previous three tax years, and membership of a registered pension scheme in the relevant year is required. The oldest available unused amount is normally used first. Tapering and the money purchase annual allowance can complicate the calculation. A spreadsheet can organise supplied figures, but it should not conceal assumptions or substitute for a competent tax calculation.

A Pension Savings Statement is an alert and calculation record, not a tax bill. It may show that NHS scheme growth exceeds the standard annual allowance, but liability depends on the full pension position, available

allowance and carry forward. Conversely, not receiving a statement does not prove there is no liability, particularly where employer data is incomplete or other schemes are involved. The taxpayer remains responsible for meeting HMRC requirements.

Record the following for each year: tax year; administrator; pension input amount; statement issue and revision dates; other pension input; standard or tapered allowance; carry forward used; calculated excess; adviser or calculation source; return amendment; charge paid personally or through scheme pays; and any remedy revision. If a figure changes, retain both versions and the explanation. Do not overwrite the history.

Where records arrive late, contact HMRC or obtain tax advice promptly rather than assuming delay removes the obligation. NHSBSA reported delays affecting some 2024–25 statements in early 2026, illustrating why current administrator notices must be checked. The response depends on the tax year and facts. A generic book cannot set a safe filing strategy for a reader whose statement is revised.

The annual-allowance decision has four gates. Is the pension input data complete? Which tax-year limits apply? Is carry forward available after considering all schemes? If a charge arises, how will it be reported and paid? Only after those questions should the member compare personal payment with any scheme-pays facility. The existence of an election mechanism does not answer whether using it is financially preferable.

A simplified illustration shows the workflow without calculating a reader's liability. Suppose an official NHS statement reports a pension input amount of £72,000 for 2026–27 and another registered scheme reports £3,000. The combined input is £75,000. Comparing £75,000 with the £60,000 standard allowance reveals a provisional excess of £15,000, not a £15,000 tax bill. The next checks are taper, carry forward, corrections and applicable tax rate. If £15,000 of valid unused allowance is available, there may be no charge; if not, the charge is based on the taxable excess at the individual's marginal rate. [125][126] Every number in this illustration is an assumption except the dated standard allowance.

The same illustration changes if adjusted income triggers taper, if the statement is revised following remedy, or if the individual had no registered-scheme membership in a carry-forward year. It changes again if a defined-contribution arrangement has been flexibly accessed. This is why calculators should display input sources and tax-year rules rather than only a result. A result without a visible audit trail is hard to check or correct.

Annual allowance is assessed by tax year, whereas NHS pay awards may be announced, made effective and paid on different dates. Keep all three. Do

not allocate a lump-sum arrears payment to earlier years for tax merely because the award was backdated, unless the applicable tax rules and official documents support that treatment. Pension input attribution may follow its own calculation. Specialist medical tax advisers are valuable because they understand this mismatch between payroll events and pension measurement.

Where an employer offers a local policy intended to support clinicians affected by pension tax, obtain the written eligibility and tax treatment. Local recycling, compensation or flexible-working arrangements are not national scheme benefits and can change. The doctor should understand whether the payment is pensionable, taxable, discretionary and conditional. The existence of a local option does not make opting out the default.

## Taper and other pensions

For 2026–27, tapered annual allowance can apply only when both threshold income exceeds £200,000 and adjusted income exceeds £260,000. Above the adjusted-income threshold, the allowance is reduced under HMRC's formula, subject to a minimum tapered annual allowance of £10,000 for that tax year. [125] These are gross tax concepts with statutory adjustments, not simply salary thresholds. A doctor's NHS basic pay below £200,000 does not automatically rule out taper where other income and adjustments alter the calculation.

Threshold income broadly starts from taxable income after particular deductions and adds back certain arrangements; adjusted income also accounts for pension growth or employer contributions under the rules. Salary, private practice, property income, investment income and other taxable sources may matter. The exact statutory calculation belongs with HMRC guidance or a competent tax adviser. Estimating adjusted income by adding the employer contribution rate to salary can be materially wrong for a defined-benefit member.

All registered pension saving matters. A doctor may have the NHS defined-benefit pension, an NHS money-purchase additional voluntary contribution arrangement, a personal pension from earlier work and another employer's scheme. Flexible access to defined-contribution benefits can trigger the money purchase annual allowance, which is £10,000 for 2026–27, and can alter the available allowance for money-purchase saving. [125] Drawing an NHS defined-benefit pension is not automatically the same event as flexibly accessing a personal defined-contribution pot.

Salary sacrifice, charitable giving, unused allowance and the treatment of contributions can affect the calculation, but they should not be presented as universally beneficial tax planning. An arrangement that reduces taxable

income may affect employment benefits, pensionable pay or other entitlements. Obtain an explanation of both the tax and employment consequences before changing it.

The tapered-allowance worksheet asks for actual sources, not guesses: taxable income by category; pension input from every scheme; relief-at-source contributions; relevant salary-sacrifice changes; threshold-income calculation; adjusted-income calculation; allowance for the year; carry forward; and evidence source. Mark each entry supplied, calculated or estimated. A provisional estimate is useful for planning but must not silently become the self-assessment figure.

Avoid the cliff-edge misconception. Crossing the adjusted-income limit does not ordinarily reduce the allowance immediately to the minimum; taper reduces it under the statutory formula until the minimum is reached. But both threshold and adjusted income tests have to be applied correctly. A colleague with the same NHS salary may have a different allowance because of private income, pension input or reliefs. This is an area for calculation, not comparison by job title.

Future earnings forecasts should use ranges. Model pension input and income under the existing job, proposed additional programmed activity and reduced-work option, clearly labelled as estimates. The objective is to identify when another official statement or advice is needed, not to engineer work around a false precision. Clinical and career choices should remain visible alongside tax.

## Scheme pays

Scheme pays is a mechanism through which an eligible annual-allowance tax charge is paid to HMRC by the pension scheme, with a corresponding permanent reduction to the member's future pension benefits. It is not the employer paying the tax and not a waiver of the charge. The reduction is adjusted over time under scheme terms, including interest. A member comparing scheme pays with personal payment is comparing different effects on present cash and future guaranteed income.

NHS schemes distinguish mandatory scheme pays, arising where statutory conditions are met, from facilities that may permit voluntary elections in additional circumstances. Eligibility can differ by amount, scheme and tax year. The member must use the current form and guidance for the correct administration and year. An election submitted to NHSBSA does not cover a Scottish or Northern Irish liability unless that administrator's process says so.

Deadline control is essential. NHSBSA's standard election material uses 31 July in the calendar year after the relevant tax year ends as the normal deadline, while earlier deadlines and remedy-specific provisions can apply, particularly around retirement, age 75 or transfer. [128] A book should not turn that headline into a universal last date. Read the live form, record the receipt requirement, and confirm any exception in writing before relying on it.

An election may be irrevocable except where a specific correction route applies, including some remedy-related adjustments. Estimate elections may be possible where the tax figure is not final, but the member remains responsible for the appropriate declaration and later amendment. The safe file contains the statement, calculation, tax return position, election form, proof of receipt, administrator confirmation and any later adjustment.

Scheme pays has two separate numerical questions. How much charge will the scheme pay? How will that payment reduce future benefits? The first depends on tax liability and election. The second depends on scheme factors, age and the time until benefits are taken. A charge of a stated amount does not necessarily reduce annual pension by a simple fixed fraction that can be inferred from another member's experience.

Michael should ask the adviser to compare consistent scenarios: personal payment from available funds; scheme pays for the eligible amount; a mixed approach if permitted; expected retirement dates; and the effect of revised remedy statements. Assumptions about investment return, inflation, life expectancy and tax should be visible. The chapter does not select among them.

A pay rise should not be refused or an NHS pension abandoned merely because scheme pays exists or might be needed. The wider calculation includes net pay, career opportunity, pension accrual, tax and future benefits. Equally, the perceived value of the scheme does not make a tax charge irrelevant. The decision needs figures rather than slogans.

Before signing an election, complete a scheme-pays control page. It should state the tax year, final or estimated charge, scheme, mandatory or voluntary basis, deadline, retirement or transfer date, remedy status, amount elected, calculation source and professional advice. After submission, add proof of receipt and the administrator's acceptance. A self-assessment entry and a scheme election are separate acts; confirm both have been completed correctly.

If the charge later changes, do not file a new form intuitively. Follow the administrator's amendment process and HMRC requirements for that year. Record whether the revised charge increases or decreases the scheme

payment and how future benefits are adjusted. Remedy cases may have dedicated processes. Version control is part of financial safety here.

## Lifetime allowance reform and lump sum allowances

Two dates must remain distinct. The lifetime allowance tax charge was removed from 6 April 2023. The lifetime allowance itself was abolished from 6 April 2024. From 6 April 2024, new lump-sum allowances apply to relevant tax-free lump sums. Saying that the lifetime allowance was abolished in April 2023 is historically and legally inaccurate. [129]

For 2026–27, HMRC lists the standard lump sum allowance at £268,275 and the standard lump sum and death benefit allowance at £1,073,100. [125] The lump sum allowance broadly limits relevant tax-free retirement lump sums, while the lump sum and death benefit allowance also applies across relevant lump sums including certain serious-ill-health and death benefits. Excess amounts may be taxable. These are standard allowances; previous benefit events and valid protections may change the individual's available amounts.

Benefits taken before 6 April 2024 can affect the calculation after that date. HMRC's transitional rules may use previous lifetime-allowance usage to determine remaining allowances. A transitional tax-free amount certificate can be relevant where actual historic tax-free lump sums differ from the standard transitional assumption, but it has strict evidence and timing requirements. NHSBSA warns that a certificate must be obtained before the first relevant benefit crystallisation event after 5 April 2024 and that not every member benefits from applying. [129]

The practical record should show every earlier pension commencement, date, scheme, pension, tax-free lump sum, lifetime-allowance percentage used if supplied, protection certificate and later relevant lump sum. Do not assume the NHS administrator knows about benefits paid by a private scheme. Conversely, do not ask a private provider to certify NHS figures it did not produce.

Commutation decisions now need both scheme and tax analysis. The scheme estimate shows how much pension is exchanged and the lump sum produced. The tax review establishes available lump-sum allowances and the treatment of any excess. A larger permitted lump sum is not automatically the preferred choice because it permanently reduces annual income. Family needs, longevity, other income and tax all matter.

This area is particularly vulnerable to outdated web articles. Material written before April 2023 may describe a lifetime-allowance charge that no longer applies; material between April 2023 and April 2024 may refer to the

allowance during its final year; early post-reform explanations may omit transitional certificates. Use dated official guidance and treat accessible summaries as interpretation only.

Do not confuse the lump sum and death benefit allowance with a ceiling on the annual survivor's pension. The allowance concerns relevant lump sums. Scheme pensions paid to eligible dependants follow their own rules and may be taxable income for the recipient. The member's family-protection review should therefore examine lump sums and continuing pensions separately.

Anyone with fixed, individual, enhanced or other historic lifetime-allowance protection should obtain advice before changing pension saving or taking benefits. Protection can alter available lump-sum allowances and may be affected by particular actions. Retain HMRC references and certificates. A protected figure recalled from memory is not enough for a retirement application.

## Early retirement partial retirement and return

Early retirement means drawing benefits before their applicable normal pension age. The benefits are ordinarily reduced because they are expected to be paid for longer. The reduction depends on the section, age and timing, not a universal percentage that applies to every NHS pension. Obtain the administrator's current factors or an official estimate. A decision to take 1995 benefits at 60 and leave 2015 benefits until later is different from drawing every section at one date.

Partial retirement permits an eligible active member to draw some or all benefits while continuing NHS employment under the relevant rules. For England and Wales, NHSBSA states that members aged 55 or over may, with employer agreement, take 20 to 100 per cent of benefits in one or two drawdown payments, continue working and build further 2015 Scheme benefits. The new working arrangement must ordinarily reduce pensionable pay by at least 10 per cent for at least 12 months. [130] Protected minimum pension ages and complex histories can alter details.

SPPA describes a closely related Scottish process: active members can ordinarily draw 20 to 100 per cent, on no more than two partial retirements, while working, with a 10 per cent pensionable-pay reduction for the first 12 months agreed through changed employment terms. It identifies specific treatment for protected minimum pension ages and scheme order. [131] HSC Pension Service publishes its own Northern Ireland partial-retirement factsheet and application arrangements. [132] Readers must use the administrator connected to the benefits and employment concerned.

The 10 per cent test concerns pensionable pay, not merely an informal promise to work less. A reduction might come from hours, responsibility or role, but it must be agreed and documented. The revised job plan should identify clinical commitments, on-call, supporting work, leadership and cover. If duties are simply compressed into fewer paid sessions, the pension condition may be met while workload and safety deteriorate. Chapter 6's work diary and capacity analysis remain relevant.

Partial retirement generates two coordinated timetables. The employer timetable covers discussion, service planning, contractual variation, job plan and start date. The pension timetable covers estimates, remedy information, forms and processing. The benefit application should not be sent before the employment arrangement is agreed, while the employment change should not be finalised without understanding the pension assumptions. Start sufficiently early to align both.

Return after retirement is now more flexible than many older accounts suggest, and active membership of the 2015 Scheme may be possible up to the scheme's age limit, subject to current rules. [122] Nevertheless, returning can affect tax, benefit payment, abatement in limited circumstances, annual allowance and the practical meaning of retirement for the employment contract. A 24-hour break may remain relevant to some full-retirement processes even where partial retirement requires no break. Use the current administrator instructions.

Later retirement can attract increases for some benefits, while the 1995 Section has different late-retirement treatment from the 2008 and 2015 arrangements. Delaying 1995 benefits while continuing work should therefore be examined specifically. A final-salary link may matter, but the member should compare official scenarios rather than assume delay always improves value.

The employment proposal should state what will stop, what will continue, how availability changes, what responsibility remains, and how the arrangement will be reviewed. It should also address annual leave, on-call, SPA or supporting activity, indemnity, appraisal and succession. Partial retirement is not achieved safely by deleting a clinic from a timetable while retaining all associated results, correspondence and governance work.

Full retirement has its own sequence. Confirm the intended last day, notice under the employment contract, required pension application lead time, annual leave, outstanding expenses, final pay and treatment of additional roles. Establish whether a break in employment is required before any return and whether the new contract changes pension eligibility. A retirement notice should not be issued merely to obtain an estimate.

Compare dates, not labels. 'Retire at sixty' may mean drawing 1995 benefits at their normal pension age, drawing 2015 benefits early, leaving 2015 benefits deferred, or partially retiring while continuing work. Ask the administrator to state which benefits are included at each date and what remains. This makes apparent disagreements between advisers easier to diagnose.

A return-to-work offer should receive the same due diligence as a new post. Confirm grade, sessions, duties, pay, pensionability, on-call, notice and appraisal connection. Pension in payment can alter total taxable income, and continuing accrual should appear correctly. The attraction of helping a former service should not replace a written contract or recreate the work pattern the doctor deliberately left.

## Ill health death and family protection

Ill-health retirement is a scheme decision under medical and eligibility criteria; it is not the same as occupational-health advice that a doctor cannot continue in the present role. NHS schemes commonly distinguish a level related to permanent inability to perform the current job from a higher level involving permanent inability to undertake regular employment of relevant duration, but exact tests and benefits must be taken from the member's scheme and section. NHSBSA's application guidance explains the process and medical assessment for England and Wales. [133]

Timing matters. Resigning before exploring ill-health options may alter the route or benefits available. A doctor with significant illness should obtain occupational-health support, scheme information and representation before ending employment where practicable. This is not pressure to apply. It is protection against an irreversible employment decision being made without understanding a potentially relevant scheme process.

Ill-health benefits can also interact with annual allowance. A scheme's tier-two decision does not automatically establish HMRC's separate severe-ill-health test. [122] Specialist tax advice may be needed where an enhancement produces pension growth. The doctor should keep the medical application separate from tax calculations while ensuring that the adviser understands the benefit awarded.

Death-in-membership, deferred-member and pensioner benefits can differ. Active membership may provide a lump sum and pensions for eligible dependants. Leaving or opting out can change that protection. Nominations help the administrator identify intended recipients, but entitlement to a dependant's pension follows scheme rules and relationship

criteria. Review nominations after marriage, civil partnership, separation, divorce, bereavement or a change in dependants.

Family protection is not limited to completing a nomination form. Record the administrator, membership number, benefits in payment, expression-of-wish or nomination status, eligible dependants, contact route and location of key documents. A trusted person should know where to find this information without being given unnecessary access to confidential employment or patient records.

Do not assume that every lump sum will be tax free or outside the estate. Age at death, payment timing, available lump sum and death benefit allowance, recipient and scheme rules can matter. Obtain current administrator and tax advice. The purpose of the family-protection review is to reveal missing information while there is time to correct it.

Ill-health applications rely on medical evidence directed to scheme criteria, not a general account that work has become difficult. Ask who supplies reports, what consent is required, whether employment must remain open and how an appeal or review works. Maintain dignity by sharing medical information through the designated process. A manager's sympathy neither grants nor prevents the scheme benefit.

Where capacity to make financial decisions may become a concern, consider appropriate legal planning with qualified advice while capacity is present. Scheme nominations, wills, powers of attorney and dependant-benefit rules do different jobs. The pension administrator cannot infer a member's wishes from an informal family understanding. This chapter flags the need; it does not supply legal advice.

Family members should also know that pension scams can target people around retirement or transfer. Treat unsolicited contact, pressure, guaranteed returns and requests to move benefits quickly as warning signs. Use official contact details independently obtained and seek regulated advice before any transfer. A professional title or medical-sector branding is not proof of authorisation.

## A decision sequence for later career

The annual pension record check begins twelve to eighteen months before a planned material change, and earlier where records are complex. Step one is to build the membership timeline: employments, sections, pay, breaks, transfers, remedy status and other pensions. Step two is to reconcile it against official records and correct discrepancies. Step three is to obtain estimates for clearly defined dates and options. A calculation based on inaccurate service should not drive the remaining steps.

Step four is to define the employment choices independently: current duties; proposed hours; on-call; leadership; additional work; contractual variation; and succession needs. Step five connects those choices to pensionable pay, partial-retirement conditions and future 2015 accrual. Step six assembles tax evidence: Pension Savings Statements, other schemes, income, carry forward, protections and previous benefit events.

Step seven is advice preparation. Ask the pension administrator factual questions about records, eligibility, estimates and forms. Ask the employer about feasible work arrangements and job planning. Ask a specialist tax adviser to calculate tax exposure. Ask a regulated financial adviser with NHS pension expertise to compare consequential choices. Confirm regulatory status and fees before sharing documents. An interpretive website or colleague may help produce questions but should not make the final decision.

The advice preparation sheet should contain the decision required; intended date; official documents and issue dates; unresolved discrepancies; options to compare; assumptions; family priorities; health or employment constraints; other pensions and income; tax returns or charges; protections; and questions for each professional. Remove patient material and share financial identifiers only through an appropriate secure route.

Step eight records the decision and its limits. Note what was chosen, what was declined, figures relied upon, advice received, employment agreement, application receipt and review point. Circumstances can change between decision and implementation. A new pay award, health event or corrected statement may justify reconsideration before an irreversible deadline.

The retirement decision sequence ends after implementation with reconciliation: first pension payment, lump sum, tax code, continuing 2015 contributions, revised payslip and benefits remaining undrawn. Report discrepancies promptly. Retirement planning is complete only when the records match what was agreed, not when the form is posted.

Use three decision meetings rather than one overloaded conversation. The record meeting with payroll and the administrator establishes facts. The work meeting with the employer establishes feasible duties, timing and contractual changes. The advice meeting compares financial and tax consequences using the outputs of the first two. Combining them prematurely encourages each participant to answer questions outside their authority.

At each meeting, end with a written action list. Name the document to be produced, its owner, due date and effect on the decision timetable. A promise to 'look into pension' is not an action. Neither is asking the doctor to

decide before a revised estimate exists. Where deadlines conflict, escalate the scheduling problem while options remain.

Finally, keep a one-page decision summary separate from the detailed file. It should contain scheme sections, selected benefit date, employment change, tax-year issues, advice obtained, applications submitted and review dates. This summary helps the doctor explain the arrangement to payroll, an appraiser or a future adviser without disclosing every financial document.

## Worked cases

Michael receives a 2025–26 Pension Savings Statement after a salary correction and is considering partial retirement in England. He does not assume the statement is a bill or opt out. He checks that the corrected pay and remedy service are included, obtains input figures for his other pension, asks a tax adviser to assess allowance and carry forward, and requests official partial-retirement estimates for two dates. His employer separately considers a job plan that genuinely reduces pensionable pay and workload. He then compares personal payment and scheme pays with regulated advice. The process produces a decision; this case does not prescribe which option he selects.

Sara, a composite Specialty Doctor who worked in Northern Ireland before moving to Scotland, finds that one statement omits an earlier part-time post. She asks the former HSC employer what was submitted, asks HSC Pension Service what is recorded and retains the SPPA statement separately. Before considering transfer or retirement, she obtains corrected records and quotations from the relevant administrators. Similar scheme names do not turn two administrations into one record. Her first success is not a higher pension figure but a reliable evidence base from which a safe choice can be made.

Both cases use the same final control. Each doctor writes a decision statement beginning, 'The choice I need to make is...', followed by the intended date, benefits concerned and employment consequence. Beneath it they list facts confirmed, figures awaited, assumptions requiring testing and professionals whose advice is needed. Michael's statement is about drawing a defined proportion while changing work; Sara's is initially about record correction and whether to seek a transfer quotation. This discipline prevents a technical question becoming an accidental instruction to retire.

The chapter's central lesson is therefore procedural rather than promotional. The NHS pension can be understood when it is divided into scheme benefit, employment record, tax valuation and personal decision. Begin with the correct administrator and dated documents. Reconcile before

calculating. Compare like-for-like benefit dates. Treat tax thresholds as tax-year facts. Put employment changes in writing. Seek regulated or specialist advice at the boundary where evidence no longer chooses between personally consequential options. A pension decision made this way may still be difficult, but it will not be based on an invented pot, a colleague's history or a rule from the wrong nation.

The evidence file should remain maintainable after the immediate choice. Once a year, retain the new statement, reconcile pay and close completed queries. At every major change, refresh the administrator map, tax-year figures, nominations and employment assumptions. Before any retirement, transfer, opt-out, protection or scheme-pays election, retrieve the live official form and have the material consequences reviewed. This rhythm is deliberately modest: routine record care, targeted technical work when a trigger occurs, and specialist advice only where the decision demands it. It allows a doctor to understand the pension without pretending to become the scheme administrator, tax authority and financial adviser at once.

Chapter 22

# Career transitions succession and later practice

## Recognising the transition point

Michael's pension work has clarified that partial retirement is possible, but it has not decided what his next working life should contain. He remains an autonomous Associate Specialist, leads a cross-service improvement programme, supports junior doctors and provides experienced on-call judgement. He is also carrying work that accumulated because he was dependable. No successor has been identified, and several responsibilities exist mainly in colleagues' memories. His question is not simply when to retire. It is how to change intensity without leaving patients, colleagues or himself exposed.

A transition point can arise from health, energy, caring responsibilities, opportunity, organisational change, pension information or a shift in what the doctor values. These are prompts for review, not presumptions about age or commitment. A younger doctor returning from parental leave may need a substantial redesign. An older doctor may wish to continue a demanding role. A service restructure can force transition on someone who intended none. The useful question is what has changed in the relationship between the work, the person and the system.

Separate five domains before choosing an answer. Clinical scope asks which activities the doctor can and wishes to sustain safely. Employment asks about contract, hours, pay, job plan and agreed duties. Professional assurance asks about licence, appraisal, revalidation, indemnity and competence. Pension and tax asks about scheme benefits, estimates and consequences. Personal life asks about health, family, geography, identity and financial need. A change in one domain may not require the same change in all five.

Michael begins with an evidence-led review rather than a retirement date. He records what he does across four representative weeks, identifies decisions for which he holds authority, distinguishes recurring from exceptional work, and notes which tasks could stop, transfer or continue. He compares this with his job plan and role descriptions. The resulting gap is uncomfortable: much of his coordination is real but informal. That is precisely why transition planning must start before the last working month.

The transition trigger sheet has four questions. What is becoming less sustainable? What do I want to protect? What might become possible? What information is missing? Answers should be specific. 'Work is too much' becomes 'two late clinics and the following on-call night now create unsafe fatigue'. 'I want more balance' becomes 'I want one predictable non-working day and no routine responsibility for the rota'. Specificity creates options other than staying unchanged or leaving completely.

Do not wait for certainty. Early planning can preserve choice even if no change follows. Obtaining pension estimates does not commit a doctor to retirement. Discussing reasonable adjustments does not concede incapacity. Identifying a successor does not make current leadership disposable. A review is successful when it turns an approaching change into a set of decisions with evidence, owners and dates.

There are warning signs that a review has been delayed. The doctor repeatedly covers gaps that are no longer exceptional; planned leave produces anxiety because nobody else can make routine decisions; recovery after on-call takes longer; professional development is postponed to keep the service running; or retirement is discussed only as escape. None proves that the doctor must leave. Each indicates that work design, support and future options deserve an honest examination.

Invite one trusted challenge to the initial self-assessment. A colleague, occupational-health professional, appraiser or mentor may notice that the proposed solution protects the organisation more than the doctor, or that the doctor is abandoning valued work unnecessarily. The challenge should clarify evidence and choices, not decide the future. Record what changed in the plan and what remained a personal preference.

There may still be ambivalence. A doctor can welcome reduced intensity and miss the team, feel relief and question the decision, or discover that a carefully designed portfolio role is not satisfying. Build a personal review at three, six and twelve months. Ask what is working, what has drifted, whether health and relationships have changed, and whether another employment, pension or professional decision is approaching. Seeking support is compatible with having planned well.

## Changing intensity within the same career

Changing intensity can mean fewer programmed activities, altered clinical content, reduced on-call, a different distribution between direct clinical care and supporting activity, release of a leadership role, or addition of portfolio work outside the main employer. These changes have different consequences. A ten per cent reduction in paid time is not necessarily a ten

per cent reduction in responsibility, and relinquishing on-call may alter service contribution more than the hours alone suggest.

Start with the work rather than the proposed number of sessions. Use the method in Chapters 6 and 7 to identify direct activity, linked administration, predictable overruns, travel, governance, teaching, leadership and availability. Mark each item retain, adapt, transfer or stop. If an activity is retained, identify the time and resource required. If it transfers, identify the receiving role and handover. If it stops, record who accepts the service consequence. This prevents a nominal reduction that leaves hidden work unchanged.

For Michael, one possible model retains two complex-care clinics, ward leadership on defined days, supervision and a smaller improvement role. It transfers rota coordination and removes one on-call commitment. Another model preserves on-call but relinquishes leadership. These are not financially or professionally equivalent. He asks the service to consider each as an operating arrangement, with a proposed job plan and review date, rather than asking vaguely to 'wind down'.

In Great Britain, employees have a statutory right to request flexible working from the first day of employment. Current guidance allows up to two statutory requests in a twelve-month period and ordinarily requires the employer to decide, including any appeal, within two months unless an extension is agreed. [136] The right is to request and to a proper process, not an automatic right to the requested pattern. Northern Ireland has its own employment framework and advice routes; readers should not export the Great Britain timetable without checking the current position.

A contractual variation should be written. Confirm hours or programmed activities, working days, on-call, duties, pay, pensionable pay, location, start date, duration, review and whether the change is permanent or trialled. Update the job plan and objectives. An informal assurance from a supportive manager can fail after the manager moves, leaving payroll and the service operating from different assumptions.

Health-related change may engage the employer's duties concerning disability and reasonable adjustments. The conversation should distinguish the adjustment sought, functional effect, clinical safety and review evidence. Occupational health can advise on function and support, but the job plan still needs an operational agreement. A doctor should not have to disclose unnecessary diagnostic detail to every colleague for agreed arrangements to be respected.

Changing intensity can also involve saying no to replacement work. If one clinic is removed but the doctor remains the default reviewer for its

results, advice and complaints, the work has been displaced rather than reduced. Keep a short implementation log during the first eight to twelve weeks. Record what stopped, what returned, unexpected gaps and patient-safety issues. Review the model against actual work and correct it before it becomes the new hidden norm.

Professional development should continue at a proportionate level. Fewer hours do not make appraisal, mandatory learning, quality improvement or scope review disappear. The development plan may become narrower and more deliberate: maintaining competence in the continuing scope, preparing a successor, and learning for a new portfolio role. The objective is a sustainable career, not professional withdrawal by stealth.

Test the proposed week on paper. Place clinics, wards, administration, travel, meetings, supervision and predictable overruns into the actual days. Add recovery after on-call and handover. A pattern can fit the contracted hours arithmetically while remaining unworkable because every supporting task lands on a non-working day. Decide who receives results and urgent messages when the doctor is absent, and make the arrangement visible to booking, switchboard and clinical teams.

A trial period can resolve uncertainty, provided its terms are explicit. State the start and end dates, duties, pay, pension implications, success measures and process for deciding what follows. Do not call a permanent pay reduction a trial unless restoration is genuinely available. If partial-retirement eligibility depends on the reduction continuing, ensure the proposed review does not contradict the pension requirement.

## Moving employer or nation

A move requires more than a new contract. It interrupts information flows that support pay, pension, appraisal, governance and professional evidence. Begin a transfer schedule before leaving. Record the final working date, new start date, employing entities, designated body, appraisal arrangements, pension administrator, payroll contacts, annual leave, study leave, mandatory training and outstanding governance matters.

The employment pack should include the signed contract, job description, person specification, agreed starting salary and recognition of relevant service, job plan, on-call terms, pay-scale information and any written protection or transitional arrangement. Do not assume that a previous grade title carries the same contractual meaning in another nation. Chapters 4 and 5 show how to compare the actual national terms and local offer.

The professional-assurance pack needs the last appraisal outputs, current personal development plan, supporting-information cycle, formal feedback dates, scope-of-practice record and contact for governance information. The doctor must keep the designated-body connection current in GMC Online when roles change. [137] Appraisal platform access and GMC connection are related but separate; registering on the new platform does not by itself update the regulatory record.

The pension pack should show the last statement from each administrator, final payslips, P60 where applicable, membership number, pensionable pay, remedy status, added benefits and unresolved queries. England and Wales use NHSBSA, Scotland uses SPPA and Northern Ireland uses HSC Pension Service. Moving nation may create separate records and a transfer option; it does not automatically merge service. Obtain official information before deciding whether to transfer.

The portfolio pack should preserve only material the doctor is entitled to retain. Obtain authorised role confirmations, appraisal outputs and suitable summaries of projects before access closes. Check exports by opening the files and attachments. Patient records, sensitive incident material and confidential organisational documents should not be forwarded to personal accounts merely because they may later be useful. Chapter 12's evidence index provides the portable finding aid.

Outstanding concerns require a named handover. A complaint, investigation, audit action or patient-safety issue should have an owner and secure transfer route. The doctor should retain the information needed to cooperate without creating an uncontrolled parallel case file. Ask the previous and new responsible-officer teams what governance information is required and confirm completion.

At induction, compare the advertised role with the service actually encountered. Confirm supervision or peer support, local pathways, escalation, digital access, mandatory training and limits of authority. Senior experience reduces some learning needs but does not eliminate unfamiliar systems. A doctor moving from Wales to England, for example, brings capability but not automatic knowledge of the new organisation's policies or contractual processes.

The move is complete when four receipts exist: the employer confirms terms and job plan; the pension record shows the new employment correctly; the appraisal team confirms arrangements; and GMC Online shows the appropriate connection. A welcome email alone proves none of these.

Pay particular attention to timing around appraisal. A move shortly before an appraisal or revalidation submission date can leave each organisation expecting the other to provide governance information. Inform both teams, identify the period each will cover and agree who will arrange the appraisal. The GMC requires the doctor to keep the connection correct; organisational delay should be documented and followed up, not used as a reason to disengage. [137]

A nation-transfer comparison should have four columns: previous position; new national rule; new local arrangement; and action required. Use it for contract, pay, appraisal, pension and development. This prevents a familiar word such as Specialist, job plan or appraisal carrying assumptions from the previous system. Preserve the source and date for every national claim, because the transfer may be revisited years later during a pay or pension query.

## Partial retirement as an employment and pension decision

Partial retirement illustrates why the domains must be coordinated. Under current NHSBSA guidance for England and Wales, an eligible member aged 55 or over may, with employer agreement, take between 20 and 100 per cent of benefits in up to two drawdown payments while continuing NHS work and building further 2015 Scheme benefits. Pensionable pay must ordinarily reduce by at least ten per cent and remain reduced for at least twelve months. [130] SPPA publishes a closely related Scottish framework, while HSC Pension Service has its own Northern Ireland factsheet and forms. [131] [132]

Those pension conditions do not create an entitlement to a particular employment pattern. The employer must be able to agree and implement the altered work. NHS Employers' guidance treats partial retirement as an employment conversation requiring workforce planning, timely discussion and clear contractual arrangements. [139] A pension estimate can show what benefits might be drawn; it cannot decide which clinics will cease or how an on-call rota will remain safe.

Michael develops two documents in parallel. His pension decision sheet identifies benefits, proposed percentage, remedy implications, early-retirement factors, lump sum, tax and future 2015 accrual. His employment proposal identifies the reduction in pensionable pay, revised job plan, duties transferred, on-call, leadership handover and review. A change is ready only when the assumptions in both documents agree.

If Michael reduces pay by changing responsibility rather than hours, the service must define which authority and accountability move with the role.

If he reduces hours, linked administration and unpredictable work must also be adjusted. If he gives up on-call, daytime expectations may need review rather than automatic intensification. The percentage condition should never become the sole measure of whether the new job is sustainable.

The timeline should run backwards from the intended benefit date. Allow time for record correction, official estimates, regulated advice, employer consultation, job planning, pension forms, payroll implementation and succession. Administrators publish processing expectations that can change. The actual current form and employer deadline should govern; a date copied from an older colleague's application should not.

Tax is a separate workstream. Pension in payment and salary are taxable income. Pension growth in continuing 2015 membership may create annual-allowance questions, and lump-sum allowances can matter when benefits are taken. A revised tax code after implementation may be provisional. Michael checks the first pension payment and payslip, and obtains tax advice where the combined position is uncertain.

There should be an implementation review before the end of the required reduced-pay period. Compare contracted and actual work, pensionable pay, contributions, pension received, duties transferred and successor readiness. If pay or work changes unexpectedly, ask promptly whether pension eligibility or abatement is affected. Do not wait for an annual appraisal to discover that the arrangement has drifted.

Partial retirement can be a single stage, one of two permitted stages, or part of a later full-retirement plan. It need not be described as disengagement. The doctor may continue complex clinical work, develop others and contribute differently. The quality of the arrangement depends on clear boundaries and evidence, not the percentage taken.

Build a partial-retirement risk check before agreement. Clinical risks include loss of continuity, unclear results handling and insufficient senior cover. Employment risks include compressed workload, ambiguous permanence and mismatched payroll dates. Pension risks include inaccurate service, failure to maintain the required reduction and drawing the wrong section. Tax risks include annual allowance, lump-sum allowances and combined pension-and-salary income. Personal risks include reduced flexibility or a pattern that does not deliver the intended recovery time. Each risk needs a control and owner.

The employer also gains information. A well-planned arrangement can retain expertise, create space for another doctor to develop and reduce dependency on one individual. These benefits should be designed, not assumed. If the service expects Michael to mentor his successor, allocate

time and define duration. If it expects him to remain available informally after retirement, convert that expectation into a legitimate role or remove it.

If the employer cannot support the first proposal, ask which element creates the problem: working days, clinical capacity, rota, leadership or timing. Generate alternatives without surrendering the purpose of the change. A refusal of one pattern does not prove that no transition is possible, while pension eligibility does not require the employer to accept an unsafe design. Representation or individual employment advice may help where agreement is difficult.

## Returning after a break

A break may follow parental leave, caring, illness, work abroad, research, a non-clinical role, suspension of practice or a deliberate career pause. Duration matters, but it is not the only determinant of support. The relevant questions are what the doctor previously did, what has changed, which capabilities may have faded, what role they will enter and what evidence can demonstrate a safe return.

Plan the return with the employer before the first clinical session. Review scope, new guidance, medicines, equipment, digital systems, pathways, emergency procedures and team changes. Agree induction, supervision, observation, simulation or refresher activity as appropriate. The GMC points to structured organisational support for doctors returning after a break and recognises that return needs should be planned rather than left to personal confidence alone. [138]

Confidence and competence are related but not interchangeable. A doctor may feel anxious while remaining capable, or feel confident despite unfamiliar systems. Use evidence: previous scope, length and nature of break, CPD, health or adjustment advice, observed practice and feedback. A graduated return can increase responsibility as defined checkpoints are met. It should not leave the doctor indefinitely working below grade without review.

Clarify licence and connection before practice resumes. Check GMC registration and licence status, designated body, appraisal arrangements, revalidation date and any conditions. A doctor without a current connection may need direct GMC guidance. The new employer should know which period lacked UK practice and how whole-practice information will be supplied. [137]

Appraisal after a break should reflect actual practice. Do not manufacture clinical evidence for a period without clinical work. Explain the break, learning undertaken, return plan and new scope. Agree a realistic personal

development plan. Where an appraisal or revalidation timetable cannot be met because information is incomplete, engage early with the responsible officer rather than assuming that the clock pauses automatically.

Health-related return needs privacy and practical planning. Occupational health may recommend adjustments or a phased return. The job plan should translate these into work, hours, location, on-call and review. Colleagues need enough information to implement agreed boundaries, not the doctor's full medical history. If health changes capability, the response should focus on safe scope and support.

The return plan records activity, supervision, evidence and review date for each stage. For example, observe the updated electronic prescribing process; complete relevant emergency simulation; undertake clinics with defined senior access; review outcomes after four weeks; and agree the next level of autonomy. This is a tailored plan, not a universal number of supervised sessions.

Return planning should begin before the break where possible. Record current scope, appraisals, competencies, key contacts, expected changes and how professional information will be maintained. Agree what communication is appropriate during absence. A doctor on leave should not be required to continue ordinary service work to make return easier, but complete disconnection from important administrative notices may create avoidable problems. The arrangement should respect the reason for the break.

For work abroad, identify which evidence can support later whole-practice appraisal and governance. Obtain role descriptions, registration evidence, appraisals or evaluations, and contact details from the overseas organisation through legitimate routes. The UK responsible officer may need information about that practice. Translation and verification should be planned, not improvised after return.

At the first review, ask about the system as well as the individual. If the doctor struggled because access was delayed, clinics were overbooked or supervision was unavailable, the answer is not simply more personal training. Correct the organisational condition. A returner should be accountable for engaging with an appropriate plan, while the employer is accountable for making agreed support real.

## Leaving a leadership or service role

A leadership handover transfers decisions, risks, relationships and authority, not simply tasks. Michael's programme includes a monthly meeting, but the meeting is only the visible part. He also holds the rationale for earlier

decisions, knows which risks remain open, maintains links with operational managers and interprets ambiguous data. A diary invitation cannot carry that knowledge.

Begin with the role mandate. Identify who appointed the role, its purpose, authority, reporting line, time, resources and boundaries. Note where actual practice differs from the written description. If the role has grown informally, the handover should make that visible so the organisation can decide what it wants to continue. Do not quietly transfer unsupported expectations to another doctor.

Create a decision register. For each active issue, record the question, relevant evidence, decision made, date, decision-maker, rationale, dissent or uncertainty, review point and owner. Include decisions deliberately deferred and explain why. The register should link to authorised organisational records rather than copy confidential material into a personal document.

Create a risk and dependency record. Distinguish patient-safety risks, workforce vulnerabilities, financial dependencies, deadlines and relationships requiring organisational sponsorship. State current controls and escalation status. A successor should be able to see which problem is owned elsewhere and which requires action from the role. Avoid presenting personal suspicions as established risk.

Relationships need deliberate transfer. Introduce the successor to key clinical, managerial, administrative and external contacts, explaining the legitimate purpose of each relationship. Do not promise another person's cooperation. Where no successor has been appointed, identify an interim accountable owner for urgent decisions. 'The team will manage' is not a governance arrangement.

Authority must transfer on a defined date. Clarify who can approve, represent, access systems, chair meetings and receive escalations. Remove or amend access after handover in accordance with organisational policy. Continuing to make decisions unofficially may feel helpful but can undermine the successor and blur accountability. If transitional support is agreed, define its scope and end date.

The handover record has six sections: mandate and authority; current priorities; decision history; live risks; key relationships; and next ninety days. Add documents, meetings, access and development needs. Review it with the successor and the accountable executive or manager. Their confirmation does not transfer responsibility for past decisions, but it shows what information and ownership moved.

A good departure also closes loops. Inform teams who now holds the role, complete required reports, return equipment, close delegated approvals

and preserve records. Do not use a farewell message to announce unresolved governance changes. Formal communication should precede personal thanks.

Handover conversations should distinguish fact, judgement and institutional memory. A fact might be that a review is due on a stated date. Judgement might be that one option is currently safer because of specified evidence. Institutional memory might explain why an earlier proposal failed. Label the category so a successor does not treat one person's judgement as policy or discard useful history because it is not a formal decision.

Include what did not work. An honest account of an abandoned pilot, contested decision or unresolved dependency can save a successor from repeating it. Describe the evidence and decision without allocating blame. If the issue involves a live formal process, take advice on what can be shared and route records securely.

Test the handover with a scenario: if the principal risk occurred next week, would the successor know who can decide, where evidence sits and whom to contact? If not, the handover is still a list of activities. Resolve the missing authority or escalation before departure, or record it explicitly to the accountable executive.

The outgoing doctor should receive confirmation that the handover has been accepted. This does not absolve past accountability or guarantee future action. It prevents later uncertainty over whether a document was delivered and who held the role from the transfer date. Keep an appropriate factual copy in the professional record without retaining the organisation's confidential operational files.

The handover record should sit beside the transition plan. It identifies each responsibility, current owner, successor, authority-transfer date, live risk, source document and next review. Test it against the later-practice checklist: a task cannot be marked transferred in one document while the former doctor remains the unrecorded escalation route in the other.

Close the transfer only when evidence supports closure. Confirm that access and delegated authority have changed; patients and staff know the new route; the successor has received records and introductions; and the doctor's current public and professional descriptions are accurate. List any residual action with an owner and deadline. A ceremonial retirement event cannot perform these controls.

## Succession without self erasure

Succession is not proof that the previous leader was unnecessary. It is evidence that the role has been made governable. A service dependent on one person's memory, goodwill or unpaid availability is fragile, however committed that person may be. Preparing others protects the work and allows the departing doctor to reduce responsibility honestly.

Michael identifies three components rather than searching for a replica. One colleague can lead clinical standards, another has operational coordination skill, and a manager owns resources and reporting. The organisation may decide to redesign the role or appoint one successor. Michael's task is to describe the capabilities and decisions required, not select a favourite informally.

Development before appointment should be fair and visible. Opportunities to chair, analyse data, lead a review or present at governance meetings should be linked to learning and feedback. Keep an evidence record of what the developing colleague did. Do not ask them to carry responsibility without authority or time under the label of shadowing.

The outgoing leader should separate authorship, contribution and ownership. Michael may have designed a programme and can retain accurate evidence of that contribution. The organisation owns its live records and future decisions. A successor may alter the programme without rewriting Michael's history. Conversely, Michael should not claim outcomes delivered after he leaves merely because they arose from his initial work.

Recognition matters. Record the role, dates, scope, achievements, challenges and handover in appraisal and the professional portfolio. Seek factual confirmation while those able to verify it remain available. This is not vanity; it preserves an accurate career record. The same record should acknowledge the team and distinguish shared results from personal action.

Boundaries after handover should be explicit. Agree whether Michael provides scheduled mentoring, answers limited historic questions or has no continuing role. Route operational decisions to the successor. If colleagues continue to approach him, he can respond: 'I can explain the background to the March decision, but current approval now sits with the new lead.' This protects both continuity and authority.

Where no successor exists, document the organisational risk and propose interim ownership. Do not postpone retirement indefinitely to conceal a vacancy. The employer must decide whether to recruit, redistribute, pause or end the work. A responsible handover makes the consequence visible; it cannot personally solve every workforce gap.

Succession succeeds when the service retains capability, the new lead has legitimate authority and the outgoing doctor can stop. If any one is missing, the arrangement remains transitional. Schedule a final review to resolve access, residual actions and requests for continuing support.

Succession planning begins much earlier than departure. A mature role has a current description, delegated authority, deputy or cover arrangement, accessible decision record and opportunities for others to develop. These controls protect the service during ordinary leave as well as retirement. They also reveal when a leadership function has expanded beyond the time allocated to it.

Avoid cloning. A successor may bring different expertise and organise the work differently. Define required outcomes, statutory or governance duties, current risks and essential relationships; do not prescribe every personal method. Michael's experience remains available as context, but the successor needs space to exercise their own judgement within legitimate authority.

Fair succession also means advertising or selecting through the appropriate process. Private promises can exclude capable colleagues and expose the successor to questions about legitimacy. Shadowing opportunities should be accessible against transparent criteria. Where an interim appointment is necessary, document its authority, term and route to substantive appointment.

The final succession statement names what Michael retains. He retains authorship of specified work, evidence of the leadership he exercised and relationships that are genuinely personal or professional. He does not retain approval rights, organisational data or an unbounded duty to rescue the service. This is succession without self-erasure: contribution is recorded accurately while present authority moves cleanly.

For the organisation, the final test is whether the service learnt from the transition. Did the role description become clearer? Was hidden work allocated? Did another colleague gain supported development? Were risks escalated before the departure date? A good transition should improve the structure inherited by the next person. If the same dependency immediately forms around them, the succession transferred a vulnerability rather than resolving it.

## Maintaining licence portfolio and purpose

Reduced practice changes what must be maintained, not the duty to maintain it. A doctor who keeps a licence must continue to meet revalidation requirements, collect and reflect on supporting information across the whole

scope of practice and participate in annual appraisal through the applicable route. The doctor is responsible for keeping the GMC connection current. [137][66]

Scope should be described in the present tense. If Michael stops on-call and acute admissions, his portfolio should show that those activities ended. Historic evidence remains valuable as history but should not imply current competence. Continuing clinics, supervision and leadership need proportionate evidence. If he later wishes to resume a relinquished area, a return and competence plan may be necessary.

Good medical practice requires doctors to recognise and work within the limits of their competence and to keep professional knowledge and skills up to date. [3] Later practice should therefore be designed around current capability and appropriate support, not around the assumption that long experience makes every former activity permanently current. The same principle protects a doctor from being pressed back into a relinquished scope merely because the service remembers that they once performed it.

Indemnity or insurance must match every continuing role. Employer indemnity for NHS clinical work may not cover external teaching, expert work, private practice, voluntary activity or advice given after retirement. Confirm arrangements with the employer and defence organisation before work begins. Honorary titles and unpaid roles can still carry professional responsibility.

CPD should follow actual professional needs. A smaller scope may require less breadth but not superficiality. Maintain updates, peer contact, reflection and quality improvement relevant to the work. Avoid using accumulated historical CPD points as evidence that a current unfamiliar activity is safe. Where a role is largely educational or managerial, remain clear which activities require a licence and which professional standards apply.

Giving up the licence can be a legitimate choice for someone not practising medicine in the UK, but it should be informed. The GMC provides guidance on revalidation and the licence to practise, including routes for doctors without a licence and for restoration. A doctor should understand what work would no longer be permitted, the future restoration process, fees and evidence requirements before deciding. [66] Registration, licence, employment title and college membership are separate statuses.

Professional identity often lags behind work. Someone who has been the senior problem-solver may experience a planned reduction as loss even when desired. The practical response is not a motivational slogan. Define the contribution that will continue, relationships worth preserving, learning

or service outside the previous role, and boundaries that protect the new pattern. Purpose can be clinical, educational, scholarly, voluntary or personal; it need not reproduce the old workload.

The later-practice checklist asks: What licensed activities continue? Which organisation governs each? Who is the responsible officer? What appraisal route applies? What indemnity covers each role? Which competencies require maintenance? What evidence is collected? Which former activities have ended? What would be required to resume them? Answer annually and whenever scope changes.

If all clinical practice stops temporarily, do not assume the licence must immediately be relinquished or can be maintained indefinitely without engagement. Review the GMC route, likely duration, appraisal and revalidation requirements with the appropriate team. The answer differs from a doctor who permanently gives up UK practice. Early contact preserves options and creates a record of engagement.

Keep professional relationships without maintaining shadow responsibility. Teaching, mentoring, college work or peer networks can preserve contribution and belonging. Each role should have a remit, time commitment, confidentiality boundary and indemnity check. A retired title should not be used to imply current organisational authority.

Review digital identity as well. Employer email, prescribing credentials, clinical-system access, electronic signatures and directory entries should change with the role. Personal websites and biographies should distinguish former from current appointments. Accurate public description protects patients and colleagues from sending decisions to someone who no longer holds the role.

## The next five years

Michael's twelve-month plan begins with facts: pension records and estimates, a work diary, role mandate and proposed transition date. By month three he has an employment proposal and a succession risk recorded with the organisation. By month six, the revised job plan and pension application route are agreed, a successor or interim owner is identified and development has begun. Before implementation he confirms tax advice, appraisal connection, indemnity and communications. During the first three months of the new arrangement he audits actual work and pay. At twelve months he reviews sustainability rather than assuming success.

His five-year review has one page. It records intended clinical scope, work intensity, pension stages, professional roles, health or adjustment needs, licence and revalidation dates, financial-advice review points,

succession responsibilities and personal priorities. Each item has evidence, an owner and a review date. The plan permits change; it does not pretend to predict life.

The handbook began with doctors whose work, title, authority and recognition did not align. Its final practical task is to make a transition equally visible. Name the work that continues, transfer the work that ends, preserve evidence of contribution, and seek advice where a general rule cannot decide an individual future. Leaving well is not disappearance. It is a final act of professional judgement that protects patients, colleagues and the doctor's freedom to choose what comes next.

Use an annual transition review even when retirement is distant. Ask whether the job plan describes reality, whether pension records are correct, whether the portfolio can travel, whether someone else can cover leadership, and whether health and personal priorities remain compatible with the work. Then select no more than three actions for the next year. A review that generates twenty ambitions may conceal the one decision that matters.

At a major transition point, expand this into a twelve-month schedule. Months one to three establish facts and options. Months four to six agree employment and financial decisions. Months seven to nine develop and appoint successors, complete records and submit applications. Months ten to twelve test the arrangement, transfer authority and close residual actions. The sequence will vary, but it makes dependencies visible early enough to act.

Five years is long enough for circumstances and guidance to change. Treat the plan as a maintained hypothesis, not a contract with the future. Refresh pension figures, GMC arrangements, employment terms and personal priorities at each decision point. Preserve the reason for changing course. A responsible career is not one that follows its first plan regardless of evidence; it is one that remains intelligible as evidence changes.

For the doctor, the final test is freedom with an accurate record. Michael can describe what he contributed, what he handed over and what he now undertakes. He is neither erased from the service's history nor required to remain its informal safety net. His pension choice, job plan, licence and personal priorities form one coherent later-practice arrangement, each governed by the correct source and open to review. That is the practical meaning of a sustainable SAS career: contribution made visible, choices informed, and responsibility held only where authority, time and present commitment remain.

The twelve-month plan should then become ordinary maintenance rather than a special retirement file. Place the next appraisal, pension-record check,

job-plan review, health or adjustment review, indemnity confirmation and succession check on one calendar. At each point ask whether the work being done still matches the work authorised and supported. If it does, preserve the evidence briefly. If it does not, reopen the relevant agreement while change is still possible. Later practice remains professional practice: bounded, evidenced, connected to others and capable of ending without confusion.

# Epilogue

## Return to the opening mismatch

This handbook began with a familiar mismatch. A doctor may carry responsibility while formal documents describe less. Grade may be mistaken for capability; a job plan may preserve yesterday's service while duties expand; a portfolio may not make present scope clear. Progression and pension choices then become harder because distinct decisions have been allowed to merge.

The answer is not to create more paperwork. It is to make each important decision governable. That begins by identifying the source that applies: contract, policy, regulatory standard, person specification, pension rule or local procedure. It continues by assembling evidence that is proportionate to the question, rather than a bundle intended to impress every possible reader. The next step is a defined conversation or decision with a named owner and an intelligible route for review. Finally, the doctor must recognise the point at which general information is no longer enough and individual advice is needed.

These four disciplines—source, evidence, decision and advice boundary—do not remove uncertainty. They prevent uncertainty from being disguised as custom, hierarchy or confident assertion. They also allow the doctor to challenge an inaccurate assumption without having to challenge every aspect of the organisation at once. A request can become precise: which term governs this duty; what evidence would support the proposed allocation; who is authorised to decide; what review mechanism applies? Precision makes disagreement safer and resolution more likely.

## A maintainable SAS career

A maintainable career is not necessarily a steadily ascending one. It may include periods of consolidation, a new clinical focus, reduced hours, formal leadership, teaching, a Specialist appointment, specialist registration, a return after absence or a deliberate move away from a responsibility that no longer fits. Progress should therefore be judged against a chosen destination and a sustainable scope, not against a single ladder borrowed from another career structure.

The practical foundations remain connected. The job plan records the work, time, objectives, support and boundaries expected now. The professional portfolio preserves an accurate account of scope, contribution, learning and impact. Appraisal uses proportionate information to support

reflection and development across the whole practice. Revalidation is a separate regulatory decision supported by the responsible officer's recommendation. Progression routes then apply their own criteria: national regrading policy in Wales or Scotland, competitive recruitment to a Specialist post in England or Northern Ireland, or the GMC Portfolio Pathway for entry onto the Specialist Register. None is proved merely by longevity, and none invalidates valuable practice that is not directed towards that destination.

The same evidence may inform several decisions, but it must not be made to claim more than it shows. A service report can support appraisal reflection, job-planning workload, a recruitment example and part of a capability map. The account offered for each purpose will differ because the governing question differs. Maintaining one reliable evidence index, with clear dates, contribution statements and lawful source locations, is more useful than reproducing the same material across disconnected platforms.

Support is part of this architecture. Line managers, clinical leaders, appraisers, responsible officers, SAS advocates, mentors, supervisors, trade unions, defence organisations, pension administrators and regulated advisers have different functions. Asking the right person early is not a sign that the doctor cannot manage a career. It is often the action that prevents a manageable uncertainty from becoming an avoidable dispute, deadline or financial consequence.

## The reader's next review

The appendices turn the book's reasoning into a practical review. Once each year—and whenever work, health, employer, nation, grade or intended retirement pattern changes—set aside a protected review rather than waiting for appraisal or crisis to impose one. Begin with the current scope: what work are you actually doing, under which agreement, with what authority and support? Compare it with the job plan and contract. Record recurrent work that has become invisible, and identify activities that have ended but still appear in formal descriptions.

Then examine the evidence system. Can you retrieve an accurate scope record, agreed objectives, meaningful learning, improvement, feedback and contributions outside direct clinical care? Are confidentiality and organisational ownership respected? Does each important claim have a fair account of your own contribution? Convert missing evidence into a specific opportunity request rather than a vague intention to improve the portfolio.

Review professional assurance separately. Confirm the appraisal connection, revalidation date, responsible officer relationship, indemnity

arrangements and any conditions attached to current work. If feedback or a formal process is active, check the process, deadline, records and advice route. Do not allow an appraisal conversation to become a substitute for responding within another procedure.

Next, ask whether the present direction remains chosen. If progression is intended, name the destination and test its live criteria. If work intensity may change, obtain current pension and employment information before agreeing an irreversible date or pattern. If a leadership responsibility depends too heavily on one person, start the handover while there is still time to transfer reasoning, authority and relationships as well as tasks.

End with no more than three recorded actions. Give each an owner, evidence of completion and a review date. One may belong to the doctor; another may require the employer to provide time, access, supervision or data; a third may require specialist advice. A review that generates twenty unactioned intentions is less useful than three decisions that alter the conditions of practice.

## What becomes visible

SAS doctors should not have to make their contribution legible by exaggerating it, adopting an inaccurate title or becoming indispensable to an unsafe arrangement. The stronger course is quieter and more durable: describe the work accurately, connect it to the source that governs it, preserve evidence of judgement and contribution, and ask for decisions through the proper route. Where the rule changes, return to the current source. Where individual circumstances determine the answer, seek individual advice.

A career built in this way can withstand change without pretending that change is simple. It allows experience to be recognised, limits to be stated, development to be planned and responsibility to be transferred. The work was always there. What changes is the reader’s ability to see it clearly, explain it fairly and act on it with evidence.

# Afterword

This book is a working guide, not a substitute for a contract, policy, regulator's decision, pension estimate or advice on an individual case. That distinction has shaped both its content and its structure. It explains how the principal systems around an SAS career fit together, but repeatedly returns the reader to the live source when a date, jurisdiction, eligibility rule, local procedure or personal circumstance determines the answer.

This handbook is deliberately separate from Surviving and Thriving in the NHS. That book addresses wider entry, adaptation and professional life in the NHS. This handbook starts inside the SAS career and stays with its operating questions: what the grade means; what has been agreed; how work becomes visible; how professional practice is demonstrated; which progression route fits the intended destination; and how contribution can be sustained through change.

Many of the systems described here will continue to evolve. National contracts may be amended. Regrading policies can be replaced. GMC processes, specialty guidance, pension rules, tax thresholds and application forms can change more quickly than a printed edition. The date and source controls in the chapters and appendices are therefore part of the method, not editorial decoration. Readers should use the book to understand the question, then check the current official document before acting.

The same discipline applies to examples. The cases are composites constructed to illuminate recurring decisions. They are not accounts of identifiable doctors, services or disputes, and their outcomes should not be treated as predictions. A different contract, date, document or missing fact may alter the available route. Where legal, regulatory, employment, tax, pension or financial consequences are significant, the appropriate adviser should consider the reader's actual circumstances.

This edition has been developed alongside the free educational material at SAS Doctors Review. The website can provide corrections, updated links and accessible versions of practical tools between print editions. It does not require a reader to purchase this book, and this book does not require a reader to submit personal information to the website. Templates may be copied into an approved local system or completed on paper. Patient-identifiable, colleague-identifiable or confidential employment information should not be entered into a public browser tool.

The most useful future revision will not be the one that adds the greatest volume. It will be the one that keeps distinctions accurate, removes material that has expired, and responds to the questions SAS doctors are actually facing. Corrections and source updates should therefore be recorded

transparently. The enduring purpose is practical: to help a doctor turn experience into an accurate account, an uncertain situation into a defined question, and a professional decision into a process that can be understood and reviewed.

The book is therefore finished by the reader rather than by its final page. Its method becomes useful when applied to a current job plan, an approaching appraisal, a progression decision, an emerging concern or a later-career choice. Each careful record and properly directed question strengthens the next conversation. That is how professional work becomes visible without being overstated.

# Practical appendices

## Appendix A Four nation source navigator

### How to use the navigator

Begin with the nation in which the employment or process sits, not the doctor's home address, medical school or previous post. UK-wide professional regulation may apply alongside a national employment contract, pension administrator and appraisal system. Record the title, version or publication date of the document actually used. A bookmarked webpage is only a route to the source; it is not proof that the content has remained unchanged.

For every important decision, write:

- the question being answered;
- the nation and employing organisation;
- the source owner;
- the document title, version and date;
- the relevant paragraph, schedule or page;
- the date checked; and
- the person or organisation from whom individual advice was obtained.

### United Kingdom professional regulation

The General Medical Council owns the medical register, licensing, revalidation, Good medical practice, fitness-to-practise procedures and the Portfolio Pathway to specialist or GP registration. Begin at the GMC's official website and move to the live guidance for the precise process. For Portfolio Pathway work, use the current application guide, evidence-verification instructions, relevant curriculum and specialty-specific guidance. Do not rely on an old saved fee, evidence period or application form.

The Academy of Medical Royal Colleges publishes professional appraisal resources, while delivery arrangements are organised through the responsible officer and designated-body structures in each nation. The employing organisation's appraisal platform does not replace GMC requirements. Record both the professional source and the local delivery route.

### England

For national SAS contractual material, begin with NHS Employers and the current terms and conditions of service for Specialty Doctors and

Specialists. Use the correct schedule for job planning, pay progression, leave and other employment questions. Local policies may explain implementation but cannot silently replace national contractual rights.

NHS England provides appraisal, revalidation and responsible-officer information relevant to designated bodies in England. NHS Business Services Authority administers NHS Pension Scheme information for England and Wales. GOV.UK and HM Revenue & Customs are the primary routes for current tax rules and statutory employment information. Acas guidance applies to Great Britain, but a general Acas explanation should not be mistaken for an individual tribunal calculation or a Northern Ireland procedure.

Checked on: _____

Current documents retained at: _____

### Wales

NHS Wales Employers is the principal source hub for national workforce agreements and the Welsh SAS contract. For progression from Specialty Doctor to Specialist, use the operative All-Wales policy, the live submission material and any formally issued guidance. Confirm the policy's effective date, eligibility, service-need test, decision stages, outcome and appeal provisions before preparing a case.

Health Education and Improvement Wales supports professional development and operates the Medical Appraisal Revalidation System used in Wales. Appraisal questions should still be separated from the responsible officer's recommendation and the GMC's revalidation decision. NHS Business Services Authority is the relevant pension administrator for NHS scheme membership in Wales.

Checked on: _____

Policy or circular used: _____

### Scotland

Use the Scottish Government health workforce directorate circulars and NHS Scotland employer material for contractual and national policy questions. A Scottish progression or regrading application must be built from the current circular, not from the Welsh route or a summary written before the latest agreement. Record the circular number, effective period and any review or transitional provision.

NHS Education for Scotland and the relevant health board provide routes for appraisal and professional support. The Scottish Public Pensions Agency

administers NHS pension benefits in Scotland. Its forms, estimates and retirement rules should be used directly; an NHS Business Services Authority example may explain a shared concept but does not establish the Scottish administrative requirement.

Checked on: _____

Current circular used: _____

### Northern Ireland

Use the Department of Health in Northern Ireland, Health and Social Care workforce material and the current Northern Ireland SAS terms and conditions for employment questions. Confirm that a document applies to the correct grade and contract. Great Britain employment guidance, including Acas material, does not automatically state Northern Ireland procedure or time limits. The Labour Relations Agency is the principal public source for workplace relations guidance in Northern Ireland.

The Northern Ireland Medical and Dental Training Agency supports appraisal and revalidation delivery. The HSC Pension Service administers the Health and Social Care pension scheme. Use its current member information, forms and estimates for Northern Ireland decisions.

Checked on: _____

Current terms used: _____

### Source hierarchy check

For a high-consequence proposition, ask in order:

1. Is there legislation, a scheme regulation, regulator rule or national contract?
2. Is there an operative national policy, circular or formal application guide?
3. Does local policy implement that source, or does it add an apparently inconsistent condition?
4. Is professional guidance explaining the rule rather than creating it?
5. Is the webpage commentary, news or interpretation rather than the operative document?
6. Has an adviser confirmed how the source applies to the individual facts?

When sources appear inconsistent, preserve both versions and their dates. Do not resolve the conflict by selecting the sentence that gives the preferred answer. Identify the owner, ask for clarification in writing and keep the decision with the evidence on which it was made.

Next formal source review due: _____

### Quarterly source audit

Choose the five sources most likely to affect a current decision. Open each from its owner's main website rather than relying only on a saved deep link. Confirm that the title, status, effective date and attachments remain available. Where a page has moved, find the successor document and record whether substance changed. Archive only what organisational policy and copyright permit.

Source one and decision supported: _____

Change since last review: _____

Action required in job plan, portfolio or application: _____

Repeat for each live decision. Record "no change found" only after checking. If a professional body's summary conflicts with the source owner's document, use the summary to frame a question, not to settle the rule. Escalate unresolved differences to the policy owner or appropriate adviser and preserve the reply with the decision record.

Review owner: _____

Evidence that the source was current: _____

If ownership of the review changes, record the handover. A reminder without a named person and a decision to make is unlikely to protect a time-sensitive application.

## Appendix B Job planning toolkit

### Tool B1 preparation record

Use this sheet before a job-planning meeting. It does not reproduce a national or local form. Complete it from the applicable contract, the previous agreed job plan and evidence of the work actually undertaken.

Post and grade: _____

Employer and nation: _____

Contract or terms used, with date: _____

Current job-plan period: _____

Proposed review period: _____

Main changes since the last agreement:

_____

_____

Documents available:

- previous signed job plan;
- current rota and work schedule;
- diary of representative weeks;
- agreed objectives and review evidence;
- role descriptions for additional responsibilities;
- activity, quality and demand information;
- leave, cover and annualisation assumptions;
- correspondence identifying disputed or unresolved matters; and
- current national and local process documents.

Missing document or information: _____

Owner and date requested: _____

### Tool B2 representative work diary

Record enough weeks to show ordinary variation. Include predictable work undertaken away from the clinical area. Do not enter patient identifiers. Distinguish work required by the role from voluntary professional activity and from work belonging to another appointment.

For each entry record:

- date and start and finish times;
- location or remote working;
- category of work;
- planned or unplanned status;
- direct clinical care, supporting professional activity or other agreed category under the applicable terms;
- preparation, administration and follow-through generated by the activity;
- travel where the contract or local arrangement makes it relevant;
- cancellation, interruption or cover responsibility;
- whether the work recurs, varies seasonally or arose exceptionally; and
- the source that shows why the work was required.

Week beginning: _____

Entry 1: _____

Time and category: _____

Why it arose and what followed: _____

Entry 2: _____

Time and category: _____

Why it arose and what followed: _____

Entry 3: _____

Time and category: _____

Why it arose and what followed: _____

Pattern or variation shown by this week:

_____

### Tool B3 annualisation assumptions

Annualisation converts recurrent work into an annual view. It must expose assumptions rather than manufacture precision. Start with the applicable contractual year and agreed working pattern. Account for leave, public holidays, study leave, predictable closures, rota frequency and work that occurs only during part of the year. Do not annualise an exceptional week as if it were ordinary.

Activity being annualised: _____

Observed period and total time: _____

Reason it is representative: _____

Number of expected occurrences in the year: _____

Weeks or periods excluded, and why: _____

Cover or cancellation assumption: _____

Annual hours produced by the calculation: _____

Conversion into sessions or programmed activities under the applicable terms: _____

Uncertainty or sensitivity: _____

Evidence retained with the calculation: _____

Ask a colleague to reproduce the result from the recorded assumptions. If the result cannot be reproduced, the calculation is not ready for a decision. Keep an alternative calculation where two reasonable assumptions materially change the outcome. The meeting can then decide which assumption applies.

### Tool B4 objective builder

An objective should connect a service or professional purpose with work the doctor can influence and support the employer will provide. Avoid objectives that transfer an organisational dependency to one person or make the doctor responsible for an outcome beyond the agreed authority.

Purpose or problem: _____

Expected contribution by the doctor: _____

Measure or evidence of progress: _____

Baseline or starting position: _____

Time, data, staff, training or authority required: _____

Dependencies owned by others: _____

Expected review date: _____

What will count as complete, partly complete or no longer appropriate:

_____

How will patient safety and workload be protected while the objective is pursued?

_____

### Tool B5 proposal sheet

For each proposed change, state the present arrangement, the evidence for change, the requested agreement and any alternative that would remain workable.

Current duty or allocation: _____

Evidence from diary, activity or role: _____

Proposed duty, time or resource: _____

Contractual or policy source: _____

Effect on other commitments: _____

Patient, service or professional reason: _____

Alternative proposal: _____

Decision required from: _____

### Tool B6 meeting and agreement record

Meeting date and participants: _____

Documents considered: _____

Areas agreed: _____

Objectives agreed, including resources: _____

Activities requiring further evidence: _____

Areas not agreed and precise reason given: _____

Temporary arrangement, if any: _____

Person responsible for the next action: _____

Deadline and review date: _____

Applicable mediation or appeal route checked on: _____

Written job plan received on: _____

Corrections requested on: _____

Final status: agreed / partly agreed / not agreed / referred

### Final quality check

Before accepting or disputing the document, ask:

- Does it describe the duties that will actually be undertaken?
- Are routine administration, follow-through, governance, teaching and leadership visible?
- Are predictable variations and on-call consequences treated fairly?
- Are objectives within the doctor's influence and supported by resources?
- Are locations, timing, travel and availability expectations workable?
- Are different roles or employers kept separate?
- Are assumptions and unresolved points recorded?
- Does the written outcome match what was discussed?
- Has advice been obtained before a contractual deadline expires?

The purpose of the record is not to prove that every minute of professional life is measurable. It is to make the operating agreement sufficiently accurate that duties, support and review can be understood by both parties.

### Tool B7 testing a disputed workload

Choose one area where the written job plan and actual work differ. Define it narrowly enough to investigate. "Administration is excessive" is difficult to decide; "follow-through generated by the weekly frailty clinic regularly continues beyond its allocated time" can be tested.

Question to test: _____

Four-week observation period: _____

Planned allocation: _____

Actual recurrent work recorded: _____

Variation caused by case mix, staffing or interruption: _____

Work that could safely be redesigned, delegated or stopped: __

Work that remains necessary and by whom: _____

Resource or process change to test: _____

Review evidence and date: _____

Agree in advance how atypical weeks will be handled. A period containing leave, an unusual incident or exceptional cover may still provide useful

evidence, but it should be labelled. Where demand fluctuates, compare more than one period and explain the range. The proposal should address both time and design: increasing allocation may be justified, but so may removing duplication, changing administrative support or setting a clearer threshold for additional work.

### Tool B8 on call and work outside ordinary hours

Record the rota frequency, availability category, predictable work, call activity and recovery implications using the applicable national terms. Separate the availability supplement from time allocated or paid for work undertaken.

Rota and prospective frequency: _____

Availability commitment and location: _____

Calls, attendances and remote clinical work sampled: _____

Follow-up work created after the duty: _____

Travel and rest implications: _____

Annualisation assumptions: _____

Proposed recognition or redesign: _____

Safety concern requiring immediate action: _____

Do not wait for the annual meeting to raise an immediate fatigue or coverage risk. Use the relevant operational and clinical governance route while preserving the job-planning issue for formal resolution.

### Tool B9 multi site and portfolio roles

Map each role separately before combining the week. This prevents one employer's time from absorbing another organisation's expectations and reveals travel or transition time that sits between appointments.

Role one—duties, agreement and time: _____

Role two—duties, agreement and time: _____

Cross-site travel or transition: _____

Overlapping availability expectation: _____

Information-governance boundary: _____

Conflict or cumulative-risk control: _____

The combined view should make clear which organisation owns each objective, provides each resource and carries each governance responsibility. Professional work performed for a College, university,

regulator or independent provider should not be described as employer activity unless an agreement makes it so.

### Tool B10 follow up letter

Use neutral, specific language after the meeting:
"My understanding is that we agreed _____."

"The evidence still required is _____."

"Responsibility for providing it rests with _____ by _____."

"The unresolved point is _____."

"The applicable review, mediation or appeal provision appears to be _____, checked on _____."

Invite correction within a reasonable period. Attach or identify the evidence considered. Do not describe a proposal as agreed until the authorised process confirms it. If the written job plan differs from the meeting, identify the exact difference promptly rather than reopening every historic disagreement.

### Worked preparation example

A doctor's diary shows that a new supervision responsibility creates recurrent preparation, meetings and follow-through. The role description confirms responsibility but gives no time. The doctor separates the educational activity from ordinary clinical administration, annualises the observed pattern and proposes an allocation with objectives and review evidence. The employer questions whether the first month is representative because several trainees required additional support. Both parties agree a further sampling period and a temporary arrangement. The record names the data to be reviewed and the date of the decision. This is progress even though the final allocation remains open: the disagreement has become a testable question with an owner and timetable.

### Employer dependency check

For every proposed objective or service change, identify what must be supplied by the organisation. This may include staffing, equipment, information, estate, administrative support, access to meetings, supervision or authority to alter a process.
Dependency: _____

Responsible owner: _____

Delivery date: _____

Evidence if delivery is delayed: _____

Effect on objective or workload: _____

Agreed adjustment: _____

At review, distinguish performance within the doctor's control from an outcome prevented by an unmet dependency. Record changed circumstances prospectively. Do not leave the objective unchanged and later treat the missing organisational input as evidence that the doctor failed. If patient safety is affected, use the appropriate governance route rather than waiting for pay progression or the next annual job-plan cycle.

## Appendix C Appraisal and professional portfolio toolkit

### Tool C1 twelve week preparation plan

Begin early enough to correct scope and access problems without turning the final week into document collection.

Twelve to nine weeks before:

- confirm appraiser, date, designated body and responsible officer connection;
- review the whole scope of practice, including separate employers and professional roles;
- check which supporting information is due and which evidence cycle applies;
- request missing feedback, authorised activity information or role confirmation; and
- identify any active process requiring separate advice.

Eight to five weeks before:

- select proportionate evidence across the whole scope;
- update the previous personal development plan honestly;
- write concise reflections focused on learning and change;
- remove unnecessary identifiers and check sharing permissions; and
- discuss reasonable adjustments or practical support early.

Four to two weeks before:

- complete the required submission on the approved system;
- check that attachments open and dates are correct;
- explain gaps rather than filling them with weak material;
- identify three matters that need a genuine appraisal conversation; and
- retain confirmation of submission.

After appraisal:

- read the summary before agreeing it;
- correct factual inaccuracies promptly;
- record the personal development plan and dependencies;
- preserve the agreed output in an authorised location; and
- schedule actions and the next evidence review.

### Tool C2 whole practice scope record

Role or appointment: _____

Organisation and nation: _____

Dates and working pattern: _____

Clinical or professional duties: _____

Governance, supervision and indemnity arrangements: _____

Information included in this appraisal: _____

Information not yet available, with reason: _____

Material change or risk to discuss: _____

Repeat this record for every place in which a licence is used, including occasional and independent work. If a role has ended, record its end date and relevant unresolved follow-through.

### Tool C3 core evidence index

Create one entry for each useful item. The index may point to an approved location rather than contain the document itself.

Evidence identifier: _____

Activity title and dates: _____

Scope or role concerned: _____

Your contribution: _____

What the item directly demonstrates: _____

Possible purpose: appraisal / job plan / progression / recruitment / Portfolio Pathway / other

Source location and access restriction: _____

Status: draft / approved / superseded / verification required

Permission or anonymisation action: _____

Missing complementary evidence: _____

Review or archive date: _____

### Tool C4 structured reflection

Use the event or information as a prompt for learning, not as an invitation to reproduce confidential detail.

What was the professional situation, described without unnecessary identifiers?

_____

What did I notice, decide or contribute?

_____

What evidence or feedback challenged my first interpretation?

_____

What did I learn about my practice, team or system?

_____

What changed, or what will I test next?

_____

How will I know whether the change is useful and sustained?

_____

What should remain a separate incident, complaint, employment or legal response?

_____

### Tool C5 PDP builder

Development need: _____

Why it matters to current or intended scope: _____

Specific action by the doctor: _____

Opportunity, time, supervision or resource required: _____

Person responsible for providing that support: _____

Evidence of progress: _____

Target and interim review dates: _____

Alternative if the opportunity is unavailable: _____

Outcome at review: complete / partly complete / changed / discontinued
Learning and next decision: _____

Avoid making attendance the outcome unless attendance itself is the genuine need. A stronger outcome explains what new capability, change in practice or tested contribution should result. Preserve dependencies so that an organisational failure to provide agreed access is not rewritten as personal non-achievement.

### Tool C6 portfolio maintenance cycle

Each quarter:

- update scope and appointment changes;
- index a small number of meaningful items;
- record contribution and outcome while they can still be verified;
- request authorised summaries before access is lost;
- review evidence gaps against intended destinations; and
- remove unnecessary duplicates through the approved process.

At career change:

- separate personal professional records from organisational records;
- arrange lawful retention or later access;
- obtain factual confirmation of roles and contributions;
- export agreed appraisal outputs in a readable form;
- check future appraisal and responsible-officer connection; and
- update the portfolio so former responsibilities do not appear current.

The portfolio is ready when it supports an honest answer efficiently. Volume is not a completion measure. Appraisal acceptance does not prove that the same item meets a recruitment or Portfolio Pathway standard.

### Tool C7 evidence quality review

Select one important claim and test the chain supporting it.
Claim stated in one sentence: _____

Primary record of the activity: _____

My identifiable contribution: _____

Result or present status: _____

Independent confirmation and basis of knowledge: _____

Learning or change in practice: _____

Limitation that a fair reader should know: _____

Next evidence needed: _____

Strong verbs require specific support. “Led”, “designed”, “implemented”, “assessed” and “supervised” are different claims. If the evidence shows contribution rather than sole leadership, change the verb. If a result belongs to a team, describe the team result and your part in it.

### Tool C8 confidentiality and sharing check

Before copying or uploading any material, ask:

- Does it contain direct or indirect patient identifiers?

- Could a colleague, complainant or small service be recognised from the combination of facts?
- Is the document an organisational record, and do I have authority to retain or share it?
- Can an approved aggregate summary demonstrate the point instead?
- Does the recipient require the whole document or only an extract?
- Is the transfer method approved and access appropriately restricted?
- Has the material been checked after redaction rather than assumed safe?

Document and intended recipient: _____

Permission or lawful route: _____

Identifiers or contextual clues removed: _____

Approved location and retention review: _____

Do not place sensitive material into a public website, general-purpose browser form or unapproved artificial-intelligence service. Anonymisation is not achieved merely by removing a name if the remaining facts permit re-identification. Where doubt remains, seek information-governance advice before copying.

### Tool C9 appraisal conversation brief

The submission provides evidence; the brief protects the purpose of the conversation.

Three matters I need to think through:

1. _____

2. _____

3. _____

Change in scope or responsibility: _____

Success or difficulty I may be underplaying: _____

Feedback that requires exploration: _____

Support or development that depends on my employer: _____

Matter that belongs to another process: _____

The appraiser can help reflection and development but cannot necessarily determine a contractual dispute, investigate an incident or promise an employment resource. Name these boundaries so that the appraisal summary records an appropriate action rather than an apparent resolution.

### Tool C10 closing an evidence year

At the end of the cycle, create a short index of agreed outputs, completed objectives, incomplete work and material carried forward. Explain why an item remains open. Archive superseded drafts according to organisational rules, and retain the approved version or a lawful reference to it. Confirm that links work outside the soon-to-close appraisal year.

Year reviewed: _____

Most important demonstrated change: _____

Objective carried forward and reason: _____

Evidence requiring future confirmation: _____

Scope change for next year: _____

Date of next quarterly review: _____

A concise closing record protects continuity when the appraiser, employer or platform changes. It also prevents an unfinished project from being presented next year as either a new activity or an unexplained failure.

### Tool C11 evidence selection test

Before adding an item to a submission, answer five questions:

1. Which requirement or appraisal discussion does it support?
2. What does it demonstrate directly, and what requires explanation?
3. Is it current enough for this purpose?
4. May it lawfully and professionally be shared in this form?
5. Would a shorter authorised summary answer the question better?

Item: _____

Decision or discussion supported: _____

Reason included: _____

Reason excluded or replaced: _____

Conversely, an elegant reflection cannot replace evidence of an activity where the receiving process requires it.

### Tool C12 deletion archive and access review

Folder or platform reviewed: _____

Active material retained: _____

Superseded duplicates handled under: _____

Material requiring organisational retention: _____

Access after role or employer change: _____

Backup or approved export tested: _____

Next review date: _____

Deletion should follow the applicable retention and governance requirements; it is not a method for removing an inconvenient professional history. Equally, keeping everything forever is not a safe portfolio strategy. Record why material is retained, where the authoritative version sits and when its continuing need will be reconsidered.

## Appendix D Specialist progression toolkit

### Tool D1 destination selector

Do not begin with a folder of certificates. Begin with the professional destination and the decision that would recognise it.

My intended destination is:

- broader or deeper practice within my current grade;
- progression or regrading to Specialist under a national policy;
- competitive appointment to an advertised Specialist post;
- specialist registration through the GMC Portfolio Pathway;
- formal training or another registration route;
- leadership, education, research or a portfolio career; or
- a combination that needs separate plans.

Why this destination fits my intended work:

_____

Nation, employer or regulator that owns the decision: _____

Live criteria checked on: _____

Decision-maker and likely timetable: _____

What the destination does not confer: _____

Alternative destination if circumstances change: _____

### Tool D2 capability gap map

Use the live framework or person specification for the intended destination. Copy its actual wording into your working document. For each requirement, distinguish experience from evidence and evidence from an assessor's conclusion.

Requirement or capability: _____

Current scope in which it is demonstrated: _____

Primary evidence available: _____

Supporting explanation or reflection: _____

Independent observation or confirmation: _____

Quality, outcome or impact: _____

Gap: experience / recency / breadth / depth / evidence / verification
Development opportunity required: _____

Time, supervision, data or authority required: _____

Owner and review date: _____

Repeat this map for clinical practice, judgement, communication, governance, improvement, education, leadership and any specialty-specific requirement. A blank row is useful when it produces a development request. It is dangerous only when it is concealed by a loosely related document.

### Tool D3 Wales regrading preparation

Confirm first that the current All-Wales policy applies to the doctor's contract and circumstances. Retain the operative policy and live submission form used.

Eligibility provision relied upon: _____

Current defined scope of practice: _____

Specialist capabilities demonstrated within that scope: _____

Evidence index location: _____

Existing work wholly or partly at the proposed level: _____

Evidence relevant to the policy's service-need test: _____

Line-manager discussion date: _____

Support offered or development identified: _____

If not supported, written reasons received on: _____

SAS advocate, representative or adviser contacted: _____

Central submission date and confirmation: _____

Further information or interview requirement: _____

Outcome, reasons and effective date: _____

Job-plan and employment actions following outcome: _____

Review or appeal deadline checked from live policy: _____

This route assesses capability and service need under its own policy. Budget pressure, an existing establishment description and the absence of a pre-

created vacancy may be relevant facts, but should not be allowed to replace the policy's stated test without a written decision and appropriate advice.

### Tool D4 Scotland regrading preparation

Current circular number and date: _____

Effective period or successor check: _____

Eligibility and service requirements: _____

Current scope and capability evidence: _____

Required organisational approvals or confirmations: _____

Submission route and date: _____

Assessment stage and material considered: _____

Development or workforce issue identified: _____

Outcome and written reasons: _____

Review, reconsideration or appeal route: _____

Representative or adviser: _____

Do not substitute the Welsh process, terminology or forms. A general description of progression is insufficient where the Scottish circular states eligibility, assessment or review requirements precisely. Recheck the circular immediately before submission.

### Tool D5 competitive Specialist appointment

Use this route for an advertised post in England or Northern Ireland and wherever appointment is made through open recruitment rather than regrading of the existing post.

Vacancy and closing date: _____

Nation and employing organisation: _____

National contract and local appointment documents: _____

Essential criteria copied exactly: _____

Criteria requiring clarification: _____

Evidence example for each essential criterion: _____

My contribution and result in each example: _____

Scope or opportunity gap: _____

Pre-application question and response: _____

References and declarations checked: _____

Interview examples rehearsed for context, judgement, action, result, learning and transfer: _____

The Specialist employment grade is distinct from the Specialist Register. Do not state or imply specialist registration unless it is held. Equally, do not assume that absence from the Specialist Register makes an applicant ineligible where the current person specification does not require it.

### Tool D6 Portfolio Pathway map

Specialty and intended register entry: _____

Current GMC application guide checked on: _____

Curriculum version and specialty-specific guidance: _____

Application eligibility confirmed from: _____

For each curriculum outcome record:

- the outcome and level required;
- evidence identifier and activity date;
- the setting and scope demonstrated;
- how the evidence addresses the outcome;
- recency, breadth or quality limitation;
- required verification and who can provide it;
- additional experience or evidence needed; and
- cross-reference where one item supports several outcomes.

Outcome: _____

Evidence and explanation: _____

Verification: _____

Gap and action: _____

Before submission, check that documents are readable, accurately labelled, appropriately anonymised and organised as the current guidance requires. Do not submit repeated copies merely to fill several rows. Do not ask a verifier to confirm activity outside their knowledge or authority. Record the application fee and evidence rules only after checking the live GMC page.

### Tool D7 twelve- to twenty four month development plan

Destination: _____

Three priority gaps: _____

Opportunity to address gap one: _____

Agreed supervisor, measure and date: _____

Opportunity to address gap two: _____

Agreed supervisor, measure and date: _____

Opportunity to address gap three: _____

Agreed supervisor, measure and date: _____

Job-plan change or protected time required: _____

Quarterly evidence review dates: _____

Point for changing destination or timetable: _____

The plan should create capability and credible evidence through real work. Courses may support development, but course accumulation is not a substitute for supervised opportunity, contribution, result and review.

### Tool D8 application evidence narrative

For each major example, prepare a concise account that can be adapted without changing its facts.

Context and required standard: _____

My role and authority: _____

Decision or difficulty: _____

Action I personally took: _____

Contribution of others: _____

Result and how it was measured: _____

Learning and later application: _____

Evidence identifiers: _____

Limit or uncertainty: _____

Test the account against the destination's wording. A clinically impressive example may not demonstrate the required governance, education or leadership capability. An outcome achieved by the service does not establish the applicant's individual contribution unless the connection is evidenced. Keep the wording consistent across the form, CV, portfolio and interview.

### Tool D9 opportunity request

State the capability gap and ask for a real opportunity to address it.

Capability requiring development: _____

Why it is relevant to current or intended work: _____

Proposed supervised activity: _____

Named supervisor or assessor: _____

Time, access and governance approval: _____

Expected output or observation: _____

Review point: _____

If the request cannot be supported, ask for the reason and a workable alternative. Do not undertake unfamiliar or higher-risk activity merely to generate evidence. Development must remain within competence, governance and patient-safety arrangements.

### Tool D10 route comparison review

When more than one destination remains plausible, compare the decisions rather than ranking titles.

Route one: _____

What it recognises: _____

Criteria and decision-maker: _____

Evidence and opportunities still needed: _____

Likely time, cost and employment dependency: _____

Route two: _____

What it recognises: _____

Criteria and decision-maker: _____

Evidence and opportunities still needed: _____

Likely time, cost and employment dependency: _____

Which route fits the intended work, and why? _____

Specialist employment and specialist registration may both be valuable, but one is not a lesser version of the other. A national regrading route addresses an employment decision. Competitive appointment addresses selection for a vacancy. Portfolio Pathway addresses regulatory registration. They may draw on overlapping practice evidence while retaining different standards and consequences.

### Worked progression case

An experienced doctor has independent practice, strong feedback and years of appraisal material. She is considering a Specialist post and Portfolio Pathway. Her first map reveals that much of the evidence demonstrates clinical service but little records her contribution to quality improvement, education or broader governance. She does not submit everything at once. She checks the person specification, prepares examples for the employment application and separately maps the current specialty curriculum. Some

evidence can be cross-referenced; other gaps require supervised opportunity and verification. She also asks whether the time and intended future work justify pursuing both routes concurrently. The plan remains ambitious, but it is now based on two defined decisions rather than the assumption that one successful process will automatically complete the other.

### Tool D11 independent readiness review

Ask a suitably experienced reviewer to assess the map against the live destination criteria, not against their general opinion of the doctor.
Reviewer and relevant experience: _____

Documents supplied: _____

Criteria clearly evidenced: _____

Claims requiring narrower wording: _____

Gaps requiring experience rather than more documentation: ____

Verification or recency problems: _____

Recommended sequence: _____

Review date: _____

### Final progression gate

Before submission or application, confirm:

- the destination and jurisdiction are correctly named;
- the live criteria and form have been used;
- eligibility has been checked independently of perceived merit;
- scope, capability and service need are separated where the process requires it;
- every central claim has evidence and an honest limitation;
- confidential material is appropriately prepared;
- verifiers understand the required function;
- managerial or organisational dependencies are recorded;
- the application is internally consistent; and
- feedback, review or appeal arrangements and deadlines have been checked.

Preserve the exact version sent, the evidence index and confirmation of receipt. If unsuccessful, request and analyse reasons against the stated criteria before deciding whether to appeal, develop, reapply or choose another destination. A disappointing outcome is evidence about one decision at one time; it is not a complete judgement on a career.

# Appendix E Concerns formal processes and support

## Tool E1 identify the process

Record the exact heading and sender of the communication. Do not infer that every concern is a disciplinary allegation or that an employer review is the GMC process.
Date received: _____

Sender and organisation: _____

Process named: informal feedback / complaint / patient-safety incident / claim / coroner or procurator fiscal / employer fact-finding / capability / conduct / health / GMC / other
Document or policy governing it: _____

Response deadline and how calculated: _____

Immediate restriction or instruction: _____

Decision-maker: _____

Separate related process: _____

Advice required from: defence organisation / trade union / employer / legal adviser / regulator / occupational health / other

## Tool E2 first response

- Read the complete notice and attachments.
- Preserve relevant records lawfully; do not alter or retrospectively recreate them.
- Record deadlines and acknowledge receipt where appropriate.
- Protect patient care and comply with any lawful interim instruction.
- Contact the adviser appropriate to the process before a substantive response.
- Keep confidential information within authorised channels.
- Separate a factual chronology from interpretation, reflection and advocacy.
- Avoid discussing the case widely or seeking informal statements that could compromise evidence.
- Record health or accessibility support needed to participate fairly.

Immediate actions and owners: _____

Advice obtained on: _____

### Tool E3 chronology

For each event record the date and time, source, factual event, people or roles involved, document location and any uncertainty. Distinguish what was known then from what became known later.

Event: _____

Contemporaneous source: _____

What remains uncertain: _____

Do not use the chronology to compose an unsupported admission or defensive narrative. Provide it to the appropriate adviser and adapt it to the procedure only after understanding the question being asked.

### Tool E4 advice and support record

Adviser or support service: _____

Role in this process: _____

Date and question asked: _____

Advice or action agreed: _____

Next contact and deadline: _____

Potential sources of support include a medical defence organisation, trade union or professional association, SAS advocate, trusted senior colleague, occupational health, employee assistance service, practitioner health service and personal general practitioner. Their roles differ. Emotional support should not be asked to replace procedural advice, and procedural representation should not be expected to provide clinical care.

### Closing the record

At the end of a process, retain the written outcome, conditions or actions, appeal information and evidence of completed remediation in the appropriate location. Update appraisal and professional records truthfully without reproducing unnecessary confidential detail. If an outcome corrects an earlier allegation, ensure the accurate status is available to those who legitimately need it. Seek advice about any continuing disclosure obligation rather than assuming either permanent disclosure or complete erasure.

### Parallel process check

A single event may produce several processes with different questions. Record each separately.

Process one, owner and deadline: _____

Process two, owner and deadline: _____

Information legitimately shared between them: _____

Information requiring advice before disclosure: _____

Possible effect of one timetable on another: _____

Do not assume that an employer finding determines a regulatory outcome, or that closure by one body requires another to close. Equally, do not send inconsistent factual accounts. A common verified chronology can support advice, but each response must address the legal or procedural question actually being asked.

### Reflection and remediation record

Concern or learning need, stated accurately: _____

Immediate safety action: _____

Learning activity or supervision: _____

Change in practice or system: _____

Evidence that change was applied: _____

Review of sustainability: _____

Reflection should demonstrate understanding, not perform an emotion demanded by an audience. Obtain advice where wording may affect an active legal, employment or regulatory process. Remediation is stronger when relevant change is evidenced and reviewed; completion of a course alone may show attendance without showing safer practice.

### Recovery plan

Formal correspondence can affect sleep, concentration, health and confidence long after the procedural step has ended. Record practical protection.

Clinical duties or adjustments reviewed with: _____

Confidential health support: _____

Named personal support: _____

Review date for any restriction or adjustment: _____

Plan for return to ordinary work: _____

An unresolved reputation concern should be addressed through accurate records and appropriate communication, not repeated informal explanation. Support should continue when the outcome arrives; resolution of the file does not necessarily resolve its effect on the doctor.

### Deadline and disclosure control

Deadline: _____

Source and date calculation: _____

Person who confirmed it: _____

Extension requested or agreed: _____

Submission confirmation: _____

Possible appeal or review deadline: _____

Some time limits have legal or contractual consequences and may run while a conversation continues. Do not assume that a grievance, discussion, sickness absence or request for documents pauses another clock. Obtain process-specific advice promptly, including from a representative or lawyer where appropriate.

When asked to disclose a concern or outcome, record the precise question, the recipient, the governing requirement and the advice obtained. Answer truthfully and proportionately. Do not conceal a required matter, but do not expand the answer into unrelated confidential history. If wording such as “investigation”, “finding”, “warning” or “restriction” is used, ensure it accurately describes the status on the relevant date.

Question asked: _____

Accurate status: _____

Requirement and advice: _____

Information supplied and date: _____

## Appendix F Pension preparation toolkit

### Tool F1 administrator and scheme map

Employer and nation: _____

Administrator: NHS Business Services Authority / Scottish Public Pensions Agency / HSC Pension Service / other

Scheme sections or arrangements shown on record: _____

Membership dates: _____

Employments, breaks or transfers requiring checking: _____

Remedy-period service or choice information: _____

Other pension saving to consider: _____

Nomination and contact details checked on: _____

### Tool F2 annual record check

Compare the official record with payslips and employment history. Do not assume that contributions on a payslip prove that service, pay and section have been recorded correctly.

- Are name, address and identifying details current?
- Are all employers and membership periods present?
- Are pensionable pay and working patterns plausible?
- Are breaks, reduced hours, family leave or transfers recorded?
- Are special-status, mental-health-officer or other historical features shown only where applicable?
- Has a Remediable Service Statement or other remedy information been received where expected?
- Are estimated benefits clearly distinguished from guaranteed amounts?
- Is a Pension Savings Statement available where pension input may exceed the annual allowance?
- Have discrepancies been raised in writing and tracked to correction?

Discrepancy: _____

Evidence supplied: _____

Case reference, owner and review date: _____

### Tool F3 decision brief

Decision being considered: retirement / partial retirement / reduced hours / additional work / progression / return to work / scheme pays / other

Desired decision date: _____

Official estimate requested on: _____

Employment change requiring agreement: _____

Effect on duties, hours and pensionable pay: _____

Benefits from each section and relevant pension ages: _____

Early or late retirement adjustment to verify: _____

McCloud remedy choice or uncertainty: _____

Annual-allowance information and tax years: _____

Lump-sum allowances or protection to examine: _____

Ill-health or family-protection question: _____

Application form and notice period: _____

No figure should be copied from this handbook into a personal decision. Obtain the current administrator estimate and current HMRC information. A

change in pay, back pay, corrected service or remedy adjustment can affect defined-benefit pension input differently from the cash contribution visible on a payslip.

### Tool F4 questions for advisers

For the pension administrator:

- Which service and scheme sections are included in this estimate?
- What is missing, provisional or affected by remedy work?
- Which form and processing timetable apply to the intended event?
- What happens to ongoing membership after partial retirement or return?

For the employer:

- Is the proposed reduction or change acceptable, and from which date?
- Which duties, hours, pay and job-plan responsibilities will change?
- How will the required arrangement be recorded and reviewed?

For a tax adviser:

- Which tax years and all pension arrangements must be included?
- Is carry forward relevant, and what records are needed?
- How do remedy, back pay or corrected input affect the calculation?
- What filing or payment deadline applies to these facts?

For a regulated financial adviser:

- What service is being offered and how is the adviser regulated?
- Is the advice independent or restricted, and what are the fees?
- Which assumptions and alternatives are included in the recommendation?
- How do retirement income, family needs, risk and other assets interact?

### Tool F5 controlled decision sequence

1. Correct the membership and employment record.
2. Obtain official estimates and statements for the contemplated date.
3. Define the employment change and secure written employer agreement where required.
4. Review tax exposure using current tax-year rules and all pension saving.
5. Obtain regulated or specialist advice where the consequences justify it.
6. Compare realistic alternatives, including timing and work pattern.
7. Submit the correct forms with sufficient time and retain confirmation.
8. Check the first payment, ongoing pay and future accrual after implementation.

Decision not to be made until: _____

Next evidence or advice required: _____

### Tool F6 annual allowance control

Tax year: _____

Pension Savings Statement received on: _____

All NHS and non-NHS pension saving identified: _____

Pay award, progression, back pay or correction: _____

Remedy adjustment affecting input: _____

Unused allowance information for earlier years: _____

Current threshold and adjusted-income rules checked from HMRC on: _____

Calculation reviewed by: _____

Tax return or payment deadline: _____

Scheme pays considered, advice and election deadline: _____

A Pension Savings Statement is an input to the review, not by itself a conclusion that tax is due. Conversely, absence of a statement should not be treated as proof that no charge can arise, particularly where several arrangements or corrected records are involved. Use current HMRC rules and obtain specialist advice when calculations are uncertain.

### Tool F7 scheme pays record

Facility considered: mandatory / voluntary / both

Charge and tax year: _____

Current scheme guidance and form: _____

Normal and exceptional deadlines checked: _____

Interest or benefit-reduction explanation obtained: _____

Alternative payment method considered: _____

Advice and decision date: _____

Confirmation received: _____

An election can produce a permanent reduction in future benefits and may be irrevocable under the scheme rules. Do not select a facility solely because it avoids an immediate cash payment. Compare the current terms and personal consequences with appropriate advice.

### Worked later career case

A senior SAS doctor has benefits in an older scheme section and the 2015 Scheme. A pay increase is followed by a Pension Savings Statement, while the doctor is also considering partial retirement. The correct sequence is not to choose a retirement date from an online estimate. The doctor first checks membership and remedy information, obtains an official estimate for the contemplated benefits, and asks the employer to define the feasible reduction in pensionable pay and duties. A tax adviser reviews pension input and other saving for the relevant years. A regulated adviser can then compare options within the doctor's wider circumstances. The eventual decision may still involve uncertainty, but it no longer rests on folklore about a single pension age, contribution rate or tax threshold.

### Implementation check

After a retirement or partial-retirement decision takes effect, compare the outcome with the agreed plan.

First pension payment checked: _____

Benefits and lump sum compared with award notice: _____

New salary, hours and pensionable pay checked: _____

Continuing scheme membership or accrual confirmed: _____

Tax code and deductions reviewed: _____

Job plan updated and signed: _____

Nomination or family-protection record reviewed: _____

Discrepancy reported to: _____

Do not assume implementation is correct because payment has begun. An error may affect pension and salary records. Keep the employer agreement, correspondence, award notice and statements together, then schedule a later check once a tax year or pension update is available.

## Appendix G Glossary

### Employment and career terms

**Associate Specialist** — A closed SAS grade retained by doctors who hold an existing appointment under the relevant arrangements. It should not be used casually as a generic description of senior SAS work.

**Locally employed doctor (LED)** — A doctor employed on local terms rather than a nationally agreed medical grade contract. LED is an employment description, not a single level of capability or responsibility.

**SAS doctor** — An umbrella expression commonly used for Specialty Doctors, Specialists and some doctors in closed staff, associate specialist and related grades. The precise contractual grade should be stated when it affects the answer.

**Specialist** — In this book, normally the senior SAS employment grade introduced through national agreements. It is distinct from being entered on the GMC Specialist Register.

**Specialty Doctor** — A substantive SAS employment grade under the applicable national contract. Scope and seniority vary; the title alone does not state every duty or capability.

**Staff grade** — A former grade. Some doctors retain historical service or documents using the term, but it should not replace their current contractual title.

### Work and contract terms

**Annualisation** — A transparent method for converting recurrent or variable work into an annual view, with leave, frequency and other assumptions stated.

**Direct clinical care (DCC)** — Contractual classification for work directly relating to patient care, interpreted through the applicable national terms and agreed job plan.

**Job plan** — The prospective agreement recording duties, objectives, supporting resources, timing and other working arrangements. It is more than a retrospective timetable.

**On-call availability supplement** — Contractual payment linked to qualifying availability arrangements. It should not be confused with allocation of time for work actually undertaken.

**Programmed activity (PA) or session** — Units used in national medical contracts to describe scheduled work. Definitions, timing and conversion must be taken from the applicable national terms.

**Supporting professional activity (SPA)** — Work supporting professional practice, such as relevant education, appraisal preparation, governance, teaching or service development, classified under the applicable terms.

### Professional assurance terms

**Appraisal** — A confidential, formative annual professional process that considers the whole scope of practice and supporting information. It contributes to, but is not identical with, revalidation.

**Designated body** — An organisation prescribed within the responsible-officer framework to which a doctor may have a connection for revalidation purposes.

**Fitness to practise** — The GMC's regulatory concept and procedures concerning whether a doctor can practise safely and effectively within the legal framework. It is not a synonym for any complaint or employer concern.

**Good medical practice** — The GMC's core professional standards for registered doctors.

**Responsible officer** — The statutory role that supports clinical governance and makes a revalidation recommendation to the GMC for connected doctors.

**Revalidation** — The GMC process for confirming continuation of a doctor's licence, informed by a responsible officer recommendation or another defined route. It is not a certificate issued by the appraiser.

### Progression and evidence terms

**Capability** — Demonstrated ability to perform within a defined area and level of practice. It should be evidenced rather than inferred solely from time served or title.

**Curriculum** — The approved framework of outcomes and capabilities used for a specialty or training route. Portfolio Pathway applicants must use the current relevant curriculum and specialty guidance.

**Primary evidence** — In this handbook, material that directly records or demonstrates the activity or contribution claimed. The meaning remains subject to any formal scheme's own evidence rules.

**Portfolio Pathway** — The GMC route through which eligible doctors may apply for specialist or GP registration using evidence that they meet the required standard. It replaced former terminology including CESR and CEGPR for new applications.

**Regrading or progression to Specialist** — A policy route available in Wales and Scotland under their respective arrangements. It is not the ordinary route to a Specialist post in England or Northern Ireland and does not itself confer specialist registration.

**Secondary evidence** — Material that describes or interprets activity, such as a reflection, CV statement or appraisal summary, rather than directly recording every underlying element.

**Specialist Register** — The GMC register status relevant to eligibility for certain medical appointments and recognition of specialist registration. It is separate from the Specialist employment grade.

### Pension and support terms

**Annual allowance** — A tax measure limiting tax-relieved pension growth or contributions in a tax year, subject to current rules, taper and possible carry forward.

**Defined-benefit pension** — A scheme in which benefits are calculated under scheme rules rather than represented by an individual investment pot equal to contributions.

**McCloud remedy** — Arrangements addressing unlawful age discrimination arising from public-service pension reforms, including choices concerning eligible remedy-period service.

**Partial retirement** — An arrangement allowing eligible members to draw part or all of specified pension benefits while continuing employment under the relevant scheme and employer rules.

**Scheme pays** — A facility through which an eligible annual-allowance tax charge may be met by the pension scheme in exchange for a permanent reduction in benefits, under applicable conditions.

**SAS advocate** — A locally or nationally supported role intended to improve the working experience and development of SAS doctors. Authority and remit depend on the particular arrangement.

**Trade union, defence organisation and regulated adviser** — Distinct sources of representation or advice. Employment representation, medico-legal support, tax advice and regulated financial advice should not be treated as interchangeable.

**Whole scope of practice** — Every professional role in which a doctor uses their medical knowledge or licence, not only the principal NHS post.

**Verification** — Confirmation by an appropriate person or organisation that evidence is authentic or accurately represents specified work; requirements vary by process.

**Scope of practice** — The work a doctor actually undertakes, including its setting, limits, responsibilities and supporting governance.

**Service need** — A policy-specific organisational test; its meaning must be taken from the applicable progression policy.

# Appendix H Source and update note

## Edition control

Edition and source-lock date: First digital edition — 12 September 2026

Sources checked through: 12 September 2026
Corrections page reviewed for this edition: 12 September 2026

This handbook distinguishes durable explanations from rules that may change. The bibliography records sources used in preparing this edition, but a citation does not guarantee that a webpage, form, fee, threshold, policy or procedure remains current when the reader acts. Follow the source navigator, locate the live document and retain its version or date.

## High volatility material

Recheck immediately before relying on:

- national contract amendments, pay circulars and job-planning procedures;
- Welsh or Scottish Specialist progression and regrading policies;
- advertised person specifications and local recruitment requirements;
- GMC Portfolio Pathway fees, evidence rules and specialty guidance;
- GMC fitness-to-practise decision guidance and procedural stages;
- appraisal and revalidation delivery arrangements;
- pension forms, retirement conditions and administrator deadlines;
- annual-allowance thresholds, tax rules and lump-sum allowances; and
- employment, appeal, tribunal or court deadlines.

## Corrections and updates

The companion site at **sasdoctors.com** should be consulted for the published corrections record, updated official links and accessible versions of selected tools. A correction should state the affected edition, page or chapter, the original wording where necessary, the corrected position, the source and the date of change. A silent website amendment must not be treated as correction of a printed edition.

Readers identifying a possible error should provide the edition, precise location and a link or copy of the relevant authoritative source. Personal cases and confidential documents should not be submitted through a general website form. Questions requiring individual employment, regulatory, legal, pension, tax or financial advice should be taken to the appropriate adviser.

### Reader verification record

Question or decision: _____

Book section consulted: _____

Live official source and date checked: _____

Change or correction identified: _____

Individual advice obtained from: _____

Decision and review date: _____

The purpose of updating is not to make a printed handbook behave like a live rulebook. It is to preserve a reliable method: understand the issue, identify the governing source, assemble the relevant evidence, obtain the right decision and recognise when general information has reached its boundary.

### Responsibilities in using an update

An online update should be read with its scope. A corrected date may affect one paragraph without changing the chapter's wider explanation; a replaced policy may require the entire practical route to be reconsidered. Record whether the new source applies to an existing decision, a future application or a different group of doctors.

Source superseded: _____

Successor source and effective date: _____

Who is affected: _____

Action for an existing record or application: _____

Advice obtained where transition is unclear: _____

The author and publisher can correct the handbook and point readers towards official material. They cannot know the facts of an employment, regulatory or financial decision. The reader remains responsible for checking the live source and obtaining tailored advice. Organisations using a template from this book should adapt it transparently and must not present it as an official national form.

Edition checked: _____

Tool copied or adapted: _____

Local owner of adaptation: _____

Date for review: _____

Record tools securely. Blank templates contain no assurance; their value depends on evidence, review and appropriate action.

# Bibliography and source notes

The numbered entries support the factual and procedural statements indicated in the text. Worked examples, preparation methods and professional interpretation are explained in the relevant chapters. The source record was checked through 12 September 2026. Use current authoritative documents for a live decision because changing provisions may differ from those recorded for this edition.


**1 NHS Employers**

Terms and conditions and resources for the SAS contract 2021

Referenced in Chapters 1, 2, 3, 4, 5.

https://www.nhsemployers.org/articles/terms-and-conditions-and-resources-sas-contract-2021

**2 General Medical Council**

The Specialist Register

Referenced in Chapters 1, 2, 4.

https://www.gmc-uk.org/registration-and-licensing/our-registers/a-guide-to-our-registers/specialist-registration

**3 General Medical Council**

Good medical practice

Referenced in Chapters 1, 3, 4, 6, 7, 9, 10, 19, 22.

https://www.gmc-uk.org/cdn/documents/good-medical-practice-2024---english_pdf-102607294.pdf

**4 NHS Wales Employers**

Specialty Specialist and Associate Specialist SAS Doctors Wales

Referenced in Chapters 2, 3, 15.

https://thenhsalliance.org/resources/specialty-specialist-and-associate-specialist-sas-doctors-wales

**5 Department of Health Northern Ireland**

SAS 2021 Contract documentation and guidance

Referenced in Chapters 2, 3, 5, 17.

https://www.health-ni.gov.uk/publications/sas-2021-contract-documentation-and-guidance

**6 NHS Employers**

Generic capabilities framework for the new Specialist grade

Referenced in Chapters 2, 15, 16, 17.

https://www.nhsemployers.org/system/files/2022-09/Generic-capabilities-framework-for-new-specialist-grade.pdf

**7 General Medical Council**

Delegation and referral

Referenced in Chapters 2, 9.

https://www.gmc-uk.org/cdn/documents/gmc-guidance-for-doctors---delegation-and-referral_pdf-58834134.pdf

**8 General Medical Council**

Applying for specialist or GP registration

Referenced in Chapters 2, 12, 18.

https://www.gmc-uk.org/registration-and-licensing/join-our-registers/applying-for-specialist-or-gp-registration

**9 General Medical Council**

Find your connection for revalidation

Referenced in Chapters 3, 4, 10, 11.

https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/my-db-tool

**10 HM Revenue and Customs**

Income Tax rates and Personal Allowances

Referenced in Chapter 3.

https://www.gov.uk/income-tax-rates

**11 NHS Scotland**

PCS DD 2025 02 Career Progression and Regrading policy

Referenced in Chapter 3.

https://www.publications.scot.nhs.uk/files/pcs2025-dd-02.pdf

**12 NHS Business Services Authority**

NHS Pensions Member hub

Referenced in Chapters 3, 4, 21.

https://www.nhsbsa.nhs.uk/member-hub

**13 Scottish Public Pensions Agency**

NHS Scotland Pension Scheme

Referenced in Chapters 3, 21.

https://pensions.gov.scot/nhs

**14 HSC Pension Service**

HSC Pension Service

Referenced in Chapter 3.

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NHS pension annual allowance

Referenced in Chapter 21.

https://www.bma.org.uk/pay-and-contracts/pensions/pensions-tax/nhs-pension-annual-allowance

**136 Advisory, Conciliation and Arbitration Service**

Making a statutory flexible working request

Referenced in Chapter 22.

https://www.acas.org.uk/statutory-flexible-working-requests/making-a-request

**137 General Medical Council**

Revalidation for doctors with a connection

Referenced in Chapter 22.

https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/revalidation-for-doctors/revalidation-for-doctors-with-a-connection

**138 General Medical Council**

Returning to work: guidance for training organisations

Referenced in Chapter 22.

https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/welcomed-and-valued/how-can-postgraduate-training-organisations-apply-their-duties/return-to-work

### 139 NHS Employers

Partial retirement employment guidance

Referenced in Chapter 22.

https://www.nhsemployers.org/publications/partial-retirement-employment-guidance