

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.