

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.