

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.