

Career transitions succession and later practice

Recognising the transition point

Michael's pension work has clarified that partial retirement is possible, but it has not decided what his next working life should contain. He remains an autonomous Associate Specialist, leads a cross-service improvement programme, supports junior doctors and provides experienced on-call judgement. He is also carrying work that accumulated because he was dependable. No successor has been identified, and several responsibilities exist mainly in colleagues' memories. His question is not simply when to retire. It is how to change intensity without leaving patients, colleagues or himself exposed.

A transition point can arise from health, energy, caring responsibilities, opportunity, organisational change, pension information or a shift in what the doctor values. These are prompts for review, not presumptions about age or commitment. A younger doctor returning from parental leave may need a substantial redesign. An older doctor may wish to continue a demanding role. A service restructure can force transition on someone who intended none. The useful question is what has changed in the relationship between the work, the person and the system.

Separate five domains before choosing an answer. Clinical scope asks which activities the doctor can and wishes to sustain safely. Employment asks about contract, hours, pay, job plan and agreed duties. Professional assurance asks about licence, appraisal, revalidation, indemnity and competence. Pension and tax asks about scheme benefits, estimates and consequences. Personal life asks about health, family, geography, identity and financial need. A change in one domain may not require the same change in all five.

Michael begins with an evidence-led review rather than a retirement date. He records what he does across four representative weeks, identifies decisions for which he holds authority, distinguishes recurring from exceptional work, and notes which tasks could stop, transfer or continue. He compares this with his job plan and role descriptions. The resulting gap is uncomfortable: much of his coordination is real but informal. That is precisely why transition planning must start before the last working month.

The transition trigger sheet has four questions. What is becoming less sustainable? What do I want to protect? What might become possible? What information is missing? Answers should be specific. 'Work is too much' becomes 'two late clinics and the following on-call night now create unsafe fatigue'. 'I want more balance' becomes 'I want one predictable non-working day and no routine responsibility for the rota'. Specificity creates options other than staying unchanged or leaving completely.

Do not wait for certainty. Early planning can preserve choice even if no change follows. Obtaining pension estimates does not commit a doctor to retirement. Discussing reasonable adjustments does not concede incapacity. Identifying a successor does not make current leadership disposable. A review is successful when it turns an approaching change into a set of decisions with evidence, owners and dates.

There are warning signs that a review has been delayed. The doctor repeatedly covers gaps that are no longer exceptional; planned leave produces anxiety because nobody else can make routine decisions; recovery after on-call takes longer; professional development is postponed to keep the service running; or retirement is discussed only as escape. None proves that the doctor must leave. Each indicates that work design, support and future options deserve an honest examination.

Invite one trusted challenge to the initial self-assessment. A colleague, occupational-health professional, appraiser or mentor may notice that the proposed solution protects the organisation more than the doctor, or that the doctor is abandoning valued work unnecessarily. The challenge should clarify evidence and choices, not decide the future. Record what changed in the plan and what remained a personal preference.

There may still be ambivalence. A doctor can welcome reduced intensity and miss the team, feel relief and question the decision, or discover that a carefully designed portfolio role is not satisfying. Build a personal review at three, six and twelve months. Ask what is working, what has drifted, whether health and relationships have changed, and whether another employment, pension or professional decision is approaching. Seeking support is compatible with having planned well.

Changing intensity within the same career

Changing intensity can mean fewer programmed activities, altered clinical content, reduced on-call, a different distribution between direct clinical care and supporting activity, release of a leadership role, or addition of portfolio work outside the main employer. These changes have different consequences. A ten per cent reduction in paid time is not necessarily a ten

per cent reduction in responsibility, and relinquishing on-call may alter service contribution more than the hours alone suggest.

Start with the work rather than the proposed number of sessions. Use the method in Chapters 6 and 7 to identify direct activity, linked administration, predictable overruns, travel, governance, teaching, leadership and availability. Mark each item retain, adapt, transfer or stop. If an activity is retained, identify the time and resource required. If it transfers, identify the receiving role and handover. If it stops, record who accepts the service consequence. This prevents a nominal reduction that leaves hidden work unchanged.

For Michael, one possible model retains two complex-care clinics, ward leadership on defined days, supervision and a smaller improvement role. It transfers rota coordination and removes one on-call commitment. Another model preserves on-call but relinquishes leadership. These are not financially or professionally equivalent. He asks the service to consider each as an operating arrangement, with a proposed job plan and review date, rather than asking vaguely to 'wind down'.

In Great Britain, employees have a statutory right to request flexible working from the first day of employment. Current guidance allows up to two statutory requests in a twelve-month period and ordinarily requires the employer to decide, including any appeal, within two months unless an extension is agreed.^[136] The right is to request and to a proper process, not an automatic right to the requested pattern. Northern Ireland has its own employment framework and advice routes; readers should not export the Great Britain timetable without checking the current position.

A contractual variation should be written. Confirm hours or programmed activities, working days, on-call, duties, pay, pensionable pay, location, start date, duration, review and whether the change is permanent or trialled. Update the job plan and objectives. An informal assurance from a supportive manager can fail after the manager moves, leaving payroll and the service operating from different assumptions.

Health-related change may engage the employer's duties concerning disability and reasonable adjustments. The conversation should distinguish the adjustment sought, functional effect, clinical safety and review evidence. Occupational health can advise on function and support, but the job plan still needs an operational agreement. A doctor should not have to disclose unnecessary diagnostic detail to every colleague for agreed arrangements to be respected.

Changing intensity can also involve saying no to replacement work. If one clinic is removed but the doctor remains the default reviewer for its

results, advice and complaints, the work has been displaced rather than reduced. Keep a short implementation log during the first eight to twelve weeks. Record what stopped, what returned, unexpected gaps and patient-safety issues. Review the model against actual work and correct it before it becomes the new hidden norm.

Professional development should continue at a proportionate level. Fewer hours do not make appraisal, mandatory learning, quality improvement or scope review disappear. The development plan may become narrower and more deliberate: maintaining competence in the continuing scope, preparing a successor, and learning for a new portfolio role. The objective is a sustainable career, not professional withdrawal by stealth.

Test the proposed week on paper. Place clinics, wards, administration, travel, meetings, supervision and predictable overruns into the actual days. Add recovery after on-call and handover. A pattern can fit the contracted hours arithmetically while remaining unworkable because every supporting task lands on a non-working day. Decide who receives results and urgent messages when the doctor is absent, and make the arrangement visible to booking, switchboard and clinical teams.

A trial period can resolve uncertainty, provided its terms are explicit. State the start and end dates, duties, pay, pension implications, success measures and process for deciding what follows. Do not call a permanent pay reduction a trial unless restoration is genuinely available. If partial-retirement eligibility depends on the reduction continuing, ensure the proposed review does not contradict the pension requirement.

Moving employer or nation

A move requires more than a new contract. It interrupts information flows that support pay, pension, appraisal, governance and professional evidence. Begin a transfer schedule before leaving. Record the final working date, new start date, employing entities, designated body, appraisal arrangements, pension administrator, payroll contacts, annual leave, study leave, mandatory training and outstanding governance matters.

The employment pack should include the signed contract, job description, person specification, agreed starting salary and recognition of relevant service, job plan, on-call terms, pay-scale information and any written protection or transitional arrangement. Do not assume that a previous grade title carries the same contractual meaning in another nation. Chapters 4 and 5 show how to compare the actual national terms and local offer.

The professional-assurance pack needs the last appraisal outputs, current personal development plan, supporting-information cycle, formal feedback dates, scope-of-practice record and contact for governance information. The doctor must keep the designated-body connection current in GMC Online when roles change.^[137] Appraisal platform access and GMC connection are related but separate; registering on the new platform does not by itself update the regulatory record.

The pension pack should show the last statement from each administrator, final payslips, P60 where applicable, membership number, pensionable pay, remedy status, added benefits and unresolved queries. England and Wales use NHSBSA, Scotland uses SPPA and Northern Ireland uses HSC Pension Service. Moving nation may create separate records and a transfer option; it does not automatically merge service. Obtain official information before deciding whether to transfer.

The portfolio pack should preserve only material the doctor is entitled to retain. Obtain authorised role confirmations, appraisal outputs and suitable summaries of projects before access closes. Check exports by opening the files and attachments. Patient records, sensitive incident material and confidential organisational documents should not be forwarded to personal accounts merely because they may later be useful. Chapter 12's evidence index provides the portable finding aid.

Outstanding concerns require a named handover. A complaint, investigation, audit action or patient-safety issue should have an owner and secure transfer route. The doctor should retain the information needed to cooperate without creating an uncontrolled parallel case file. Ask the previous and new responsible-officer teams what governance information is required and confirm completion.

At induction, compare the advertised role with the service actually encountered. Confirm supervision or peer support, local pathways, escalation, digital access, mandatory training and limits of authority. Senior experience reduces some learning needs but does not eliminate unfamiliar systems. A doctor moving from Wales to England, for example, brings capability but not automatic knowledge of the new organisation's policies or contractual processes.

The move is complete when four receipts exist: the employer confirms terms and job plan; the pension record shows the new employment correctly; the appraisal team confirms arrangements; and GMC Online shows the appropriate connection. A welcome email alone proves none of these.

Pay particular attention to timing around appraisal. A move shortly before an appraisal or revalidation submission date can leave each organisation expecting the other to provide governance information. Inform both teams, identify the period each will cover and agree who will arrange the appraisal. The GMC requires the doctor to keep the connection correct; organisational delay should be documented and followed up, not used as a reason to disengage. ^[137]

A nation-transfer comparison should have four columns: previous position; new national rule; new local arrangement; and action required. Use it for contract, pay, appraisal, pension and development. This prevents a familiar word such as Specialist, job plan or appraisal carrying assumptions from the previous system. Preserve the source and date for every national claim, because the transfer may be revisited years later during a pay or pension query.

Partial retirement as an employment and pension decision

Partial retirement illustrates why the domains must be coordinated. Under current NHSBSA guidance for England and Wales, an eligible member aged 55 or over may, with employer agreement, take between 20 and 100 per cent of benefits in up to two drawdown payments while continuing NHS work and building further 2015 Scheme benefits. Pensionable pay must ordinarily reduce by at least ten per cent and remain reduced for at least twelve months. [130] SPPA publishes a closely related Scottish framework, while HSC Pension Service has its own Northern Ireland factsheet and forms. [131] [132]

Those pension conditions do not create an entitlement to a particular employment pattern. The employer must be able to agree and implement the altered work. NHS Employers' guidance treats partial retirement as an employment conversation requiring workforce planning, timely discussion and clear contractual arrangements. ^[139] A pension estimate can show what benefits might be drawn; it cannot decide which clinics will cease or how an on-call rota will remain safe.

Michael develops two documents in parallel. His pension decision sheet identifies benefits, proposed percentage, remedy implications, early-retirement factors, lump sum, tax and future 2015 accrual. His employment proposal identifies the reduction in pensionable pay, revised job plan, duties transferred, on-call, leadership handover and review. A change is ready only when the assumptions in both documents agree.

If Michael reduces pay by changing responsibility rather than hours, the service must define which authority and accountability move with the role.

If he reduces hours, linked administration and unpredictable work must also be adjusted. If he gives up on-call, daytime expectations may need review rather than automatic intensification. The percentage condition should never become the sole measure of whether the new job is sustainable.

The timeline should run backwards from the intended benefit date. Allow time for record correction, official estimates, regulated advice, employer consultation, job planning, pension forms, payroll implementation and succession. Administrators publish processing expectations that can change. The actual current form and employer deadline should govern; a date copied from an older colleague's application should not.

Tax is a separate workstream. Pension in payment and salary are taxable income. Pension growth in continuing 2015 membership may create annual-allowance questions, and lump-sum allowances can matter when benefits are taken. A revised tax code after implementation may be provisional. Michael checks the first pension payment and payslip, and obtains tax advice where the combined position is uncertain.

There should be an implementation review before the end of the required reduced-pay period. Compare contracted and actual work, pensionable pay, contributions, pension received, duties transferred and successor readiness. If pay or work changes unexpectedly, ask promptly whether pension eligibility or abatement is affected. Do not wait for an annual appraisal to discover that the arrangement has drifted.

Partial retirement can be a single stage, one of two permitted stages, or part of a later full-retirement plan. It need not be described as disengagement. The doctor may continue complex clinical work, develop others and contribute differently. The quality of the arrangement depends on clear boundaries and evidence, not the percentage taken.

Build a partial-retirement risk check before agreement. Clinical risks include loss of continuity, unclear results handling and insufficient senior cover. Employment risks include compressed workload, ambiguous permanence and mismatched payroll dates. Pension risks include inaccurate service, failure to maintain the required reduction and drawing the wrong section. Tax risks include annual allowance, lump-sum allowances and combined pension-and-salary income. Personal risks include reduced flexibility or a pattern that does not deliver the intended recovery time. Each risk needs a control and owner.

The employer also gains information. A well-planned arrangement can retain expertise, create space for another doctor to develop and reduce dependency on one individual. These benefits should be designed, not assumed. If the service expects Michael to mentor his successor, allocate

time and define duration. If it expects him to remain available informally after retirement, convert that expectation into a legitimate role or remove it.

If the employer cannot support the first proposal, ask which element creates the problem: working days, clinical capacity, rota, leadership or timing. Generate alternatives without surrendering the purpose of the change. A refusal of one pattern does not prove that no transition is possible, while pension eligibility does not require the employer to accept an unsafe design. Representation or individual employment advice may help where agreement is difficult.

Returning after a break

A break may follow parental leave, caring, illness, work abroad, research, a non-clinical role, suspension of practice or a deliberate career pause. Duration matters, but it is not the only determinant of support. The relevant questions are what the doctor previously did, what has changed, which capabilities may have faded, what role they will enter and what evidence can demonstrate a safe return.

Plan the return with the employer before the first clinical session. Review scope, new guidance, medicines, equipment, digital systems, pathways, emergency procedures and team changes. Agree induction, supervision, observation, simulation or refresher activity as appropriate. The GMC points to structured organisational support for doctors returning after a break and recognises that return needs should be planned rather than left to personal confidence alone.^[138]

Confidence and competence are related but not interchangeable. A doctor may feel anxious while remaining capable, or feel confident despite unfamiliar systems. Use evidence: previous scope, length and nature of break, CPD, health or adjustment advice, observed practice and feedback. A graduated return can increase responsibility as defined checkpoints are met. It should not leave the doctor indefinitely working below grade without review.

Clarify licence and connection before practice resumes. Check GMC registration and licence status, designated body, appraisal arrangements, revalidation date and any conditions. A doctor without a current connection may need direct GMC guidance. The new employer should know which period lacked UK practice and how whole-practice information will be supplied.^[137]

Appraisal after a break should reflect actual practice. Do not manufacture clinical evidence for a period without clinical work. Explain the break, learning undertaken, return plan and new scope. Agree a realistic personal

development plan. Where an appraisal or revalidation timetable cannot be met because information is incomplete, engage early with the responsible officer rather than assuming that the clock pauses automatically.

Health-related return needs privacy and practical planning. Occupational health may recommend adjustments or a phased return. The job plan should translate these into work, hours, location, on-call and review. Colleagues need enough information to implement agreed boundaries, not the doctor's full medical history. If health changes capability, the response should focus on safe scope and support.

The return plan records activity, supervision, evidence and review date for each stage. For example, observe the updated electronic prescribing process; complete relevant emergency simulation; undertake clinics with defined senior access; review outcomes after four weeks; and agree the next level of autonomy. This is a tailored plan, not a universal number of supervised sessions.

Return planning should begin before the break where possible. Record current scope, appraisals, competencies, key contacts, expected changes and how professional information will be maintained. Agree what communication is appropriate during absence. A doctor on leave should not be required to continue ordinary service work to make return easier, but complete disconnection from important administrative notices may create avoidable problems. The arrangement should respect the reason for the break.

For work abroad, identify which evidence can support later whole-practice appraisal and governance. Obtain role descriptions, registration evidence, appraisals or evaluations, and contact details from the overseas organisation through legitimate routes. The UK responsible officer may need information about that practice. Translation and verification should be planned, not improvised after return.

At the first review, ask about the system as well as the individual. If the doctor struggled because access was delayed, clinics were overbooked or supervision was unavailable, the answer is not simply more personal training. Correct the organisational condition. A returner should be accountable for engaging with an appropriate plan, while the employer is accountable for making agreed support real.

Leaving a leadership or service role

A leadership handover transfers decisions, risks, relationships and authority, not simply tasks. Michael's programme includes a monthly meeting, but the meeting is only the visible part. He also holds the rationale for earlier

decisions, knows which risks remain open, maintains links with operational managers and interprets ambiguous data. A diary invitation cannot carry that knowledge.

Begin with the role mandate. Identify who appointed the role, its purpose, authority, reporting line, time, resources and boundaries. Note where actual practice differs from the written description. If the role has grown informally, the handover should make that visible so the organisation can decide what it wants to continue. Do not quietly transfer unsupported expectations to another doctor.

Create a decision register. For each active issue, record the question, relevant evidence, decision made, date, decision-maker, rationale, dissent or uncertainty, review point and owner. Include decisions deliberately deferred and explain why. The register should link to authorised organisational records rather than copy confidential material into a personal document.

Create a risk and dependency record. Distinguish patient-safety risks, workforce vulnerabilities, financial dependencies, deadlines and relationships requiring organisational sponsorship. State current controls and escalation status. A successor should be able to see which problem is owned elsewhere and which requires action from the role. Avoid presenting personal suspicions as established risk.

Relationships need deliberate transfer. Introduce the successor to key clinical, managerial, administrative and external contacts, explaining the legitimate purpose of each relationship. Do not promise another person's cooperation. Where no successor has been appointed, identify an interim accountable owner for urgent decisions. 'The team will manage' is not a governance arrangement.

Authority must transfer on a defined date. Clarify who can approve, represent, access systems, chair meetings and receive escalations. Remove or amend access after handover in accordance with organisational policy. Continuing to make decisions unofficially may feel helpful but can undermine the successor and blur accountability. If transitional support is agreed, define its scope and end date.

The handover record has six sections: mandate and authority; current priorities; decision history; live risks; key relationships; and next ninety days. Add documents, meetings, access and development needs. Review it with the successor and the accountable executive or manager. Their confirmation does not transfer responsibility for past decisions, but it shows what information and ownership moved.

A good departure also closes loops. Inform teams who now holds the role, complete required reports, return equipment, close delegated approvals

and preserve records. Do not use a farewell message to announce unresolved governance changes. Formal communication should precede personal thanks.

Handover conversations should distinguish fact, judgement and institutional memory. A fact might be that a review is due on a stated date. Judgement might be that one option is currently safer because of specified evidence. Institutional memory might explain why an earlier proposal failed. Label the category so a successor does not treat one person's judgement as policy or discard useful history because it is not a formal decision.

Include what did not work. An honest account of an abandoned pilot, contested decision or unresolved dependency can save a successor from repeating it. Describe the evidence and decision without allocating blame. If the issue involves a live formal process, take advice on what can be shared and route records securely.

Test the handover with a scenario: if the principal risk occurred next week, would the successor know who can decide, where evidence sits and whom to contact? If not, the handover is still a list of activities. Resolve the missing authority or escalation before departure, or record it explicitly to the accountable executive.

The outgoing doctor should receive confirmation that the handover has been accepted. This does not absolve past accountability or guarantee future action. It prevents later uncertainty over whether a document was delivered and who held the role from the transfer date. Keep an appropriate factual copy in the professional record without retaining the organisation's confidential operational files.

The handover record should sit beside the transition plan. It identifies each responsibility, current owner, successor, authority-transfer date, live risk, source document and next review. Test it against the later-practice checklist: a task cannot be marked transferred in one document while the former doctor remains the unrecorded escalation route in the other.

Close the transfer only when evidence supports closure. Confirm that access and delegated authority have changed; patients and staff know the new route; the successor has received records and introductions; and the doctor's current public and professional descriptions are accurate. List any residual action with an owner and deadline. A ceremonial retirement event cannot perform these controls.

Succession without self erasure

Succession is not proof that the previous leader was unnecessary. It is evidence that the role has been made governable. A service dependent on one person's memory, goodwill or unpaid availability is fragile, however committed that person may be. Preparing others protects the work and allows the departing doctor to reduce responsibility honestly.

Michael identifies three components rather than searching for a replica. One colleague can lead clinical standards, another has operational coordination skill, and a manager owns resources and reporting. The organisation may decide to redesign the role or appoint one successor. Michael's task is to describe the capabilities and decisions required, not select a favourite informally.

Development before appointment should be fair and visible. Opportunities to chair, analyse data, lead a review or present at governance meetings should be linked to learning and feedback. Keep an evidence record of what the developing colleague did. Do not ask them to carry responsibility without authority or time under the label of shadowing.

The outgoing leader should separate authorship, contribution and ownership. Michael may have designed a programme and can retain accurate evidence of that contribution. The organisation owns its live records and future decisions. A successor may alter the programme without rewriting Michael's history. Conversely, Michael should not claim outcomes delivered after he leaves merely because they arose from his initial work.

Recognition matters. Record the role, dates, scope, achievements, challenges and handover in appraisal and the professional portfolio. Seek factual confirmation while those able to verify it remain available. This is not vanity; it preserves an accurate career record. The same record should acknowledge the team and distinguish shared results from personal action.

Boundaries after handover should be explicit. Agree whether Michael provides scheduled mentoring, answers limited historic questions or has no continuing role. Route operational decisions to the successor. If colleagues continue to approach him, he can respond: 'I can explain the background to the March decision, but current approval now sits with the new lead.' This protects both continuity and authority.

Where no successor exists, document the organisational risk and propose interim ownership. Do not postpone retirement indefinitely to conceal a vacancy. The employer must decide whether to recruit, redistribute, pause or end the work. A responsible handover makes the consequence visible; it cannot personally solve every workforce gap.

Succession succeeds when the service retains capability, the new lead has legitimate authority and the outgoing doctor can stop. If any one is missing, the arrangement remains transitional. Schedule a final review to resolve access, residual actions and requests for continuing support.

Succession planning begins much earlier than departure. A mature role has a current description, delegated authority, deputy or cover arrangement, accessible decision record and opportunities for others to develop. These controls protect the service during ordinary leave as well as retirement. They also reveal when a leadership function has expanded beyond the time allocated to it.

Avoid cloning. A successor may bring different expertise and organise the work differently. Define required outcomes, statutory or governance duties, current risks and essential relationships; do not prescribe every personal method. Michael's experience remains available as context, but the successor needs space to exercise their own judgement within legitimate authority.

Fair succession also means advertising or selecting through the appropriate process. Private promises can exclude capable colleagues and expose the successor to questions about legitimacy. Shadowing opportunities should be accessible against transparent criteria. Where an interim appointment is necessary, document its authority, term and route to substantive appointment.

The final succession statement names what Michael retains. He retains authorship of specified work, evidence of the leadership he exercised and relationships that are genuinely personal or professional. He does not retain approval rights, organisational data or an unbounded duty to rescue the service. This is succession without self-erasure: contribution is recorded accurately while present authority moves cleanly.

For the organisation, the final test is whether the service learnt from the transition. Did the role description become clearer? Was hidden work allocated? Did another colleague gain supported development? Were risks escalated before the departure date? A good transition should improve the structure inherited by the next person. If the same dependency immediately forms around them, the succession transferred a vulnerability rather than resolving it.

Maintaining licence portfolio and purpose

Reduced practice changes what must be maintained, not the duty to maintain it. A doctor who keeps a licence must continue to meet revalidation requirements, collect and reflect on supporting information across the whole

scope of practice and participate in annual appraisal through the applicable route. The doctor is responsible for keeping the GMC connection current. [137][66]

Scope should be described in the present tense. If Michael stops on-call and acute admissions, his portfolio should show that those activities ended. Historic evidence remains valuable as history but should not imply current competence. Continuing clinics, supervision and leadership need proportionate evidence. If he later wishes to resume a relinquished area, a return and competence plan may be necessary.

Good medical practice requires doctors to recognise and work within the limits of their competence and to keep professional knowledge and skills up to date. ^[3] Later practice should therefore be designed around current capability and appropriate support, not around the assumption that long experience makes every former activity permanently current. The same principle protects a doctor from being pressed back into a relinquished scope merely because the service remembers that they once performed it.

Indemnity or insurance must match every continuing role. Employer indemnity for NHS clinical work may not cover external teaching, expert work, private practice, voluntary activity or advice given after retirement. Confirm arrangements with the employer and defence organisation before work begins. Honorary titles and unpaid roles can still carry professional responsibility.

CPD should follow actual professional needs. A smaller scope may require less breadth but not superficiality. Maintain updates, peer contact, reflection and quality improvement relevant to the work. Avoid using accumulated historical CPD points as evidence that a current unfamiliar activity is safe. Where a role is largely educational or managerial, remain clear which activities require a licence and which professional standards apply.

Giving up the licence can be a legitimate choice for someone not practising medicine in the UK, but it should be informed. The GMC provides guidance on revalidation and the licence to practise, including routes for doctors without a licence and for restoration. A doctor should understand what work would no longer be permitted, the future restoration process, fees and evidence requirements before deciding. ^[66] Registration, licence, employment title and college membership are separate statuses.

Professional identity often lags behind work. Someone who has been the senior problem-solver may experience a planned reduction as loss even when desired. The practical response is not a motivational slogan. Define the contribution that will continue, relationships worth preserving, learning

or service outside the previous role, and boundaries that protect the new pattern. Purpose can be clinical, educational, scholarly, voluntary or personal; it need not reproduce the old workload.

The later-practice checklist asks: What licensed activities continue? Which organisation governs each? Who is the responsible officer? What appraisal route applies? What indemnity covers each role? Which competencies require maintenance? What evidence is collected? Which former activities have ended? What would be required to resume them? Answer annually and whenever scope changes.

If all clinical practice stops temporarily, do not assume the licence must immediately be relinquished or can be maintained indefinitely without engagement. Review the GMC route, likely duration, appraisal and revalidation requirements with the appropriate team. The answer differs from a doctor who permanently gives up UK practice. Early contact preserves options and creates a record of engagement.

Keep professional relationships without maintaining shadow responsibility. Teaching, mentoring, college work or peer networks can preserve contribution and belonging. Each role should have a remit, time commitment, confidentiality boundary and indemnity check. A retired title should not be used to imply current organisational authority.

Review digital identity as well. Employer email, prescribing credentials, clinical-system access, electronic signatures and directory entries should change with the role. Personal websites and biographies should distinguish former from current appointments. Accurate public description protects patients and colleagues from sending decisions to someone who no longer holds the role.

The next five years

Michael's twelve-month plan begins with facts: pension records and estimates, a work diary, role mandate and proposed transition date. By month three he has an employment proposal and a succession risk recorded with the organisation. By month six, the revised job plan and pension application route are agreed, a successor or interim owner is identified and development has begun. Before implementation he confirms tax advice, appraisal connection, indemnity and communications. During the first three months of the new arrangement he audits actual work and pay. At twelve months he reviews sustainability rather than assuming success.

His five-year review has one page. It records intended clinical scope, work intensity, pension stages, professional roles, health or adjustment needs, licence and revalidation dates, financial-advice review points,

succession responsibilities and personal priorities. Each item has evidence, an owner and a review date. The plan permits change; it does not pretend to predict life.

The handbook began with doctors whose work, title, authority and recognition did not align. Its final practical task is to make a transition equally visible. Name the work that continues, transfer the work that ends, preserve evidence of contribution, and seek advice where a general rule cannot decide an individual future. Leaving well is not disappearance. It is a final act of professional judgement that protects patients, colleagues and the doctor's freedom to choose what comes next.

Use an annual transition review even when retirement is distant. Ask whether the job plan describes reality, whether pension records are correct, whether the portfolio can travel, whether someone else can cover leadership, and whether health and personal priorities remain compatible with the work. Then select no more than three actions for the next year. A review that generates twenty ambitions may conceal the one decision that matters.

At a major transition point, expand this into a twelve-month schedule. Months one to three establish facts and options. Months four to six agree employment and financial decisions. Months seven to nine develop and appoint successors, complete records and submit applications. Months ten to twelve test the arrangement, transfer authority and close residual actions. The sequence will vary, but it makes dependencies visible early enough to act.

Five years is long enough for circumstances and guidance to change. Treat the plan as a maintained hypothesis, not a contract with the future. Refresh pension figures, GMC arrangements, employment terms and personal priorities at each decision point. Preserve the reason for changing course. A responsible career is not one that follows its first plan regardless of evidence; it is one that remains intelligible as evidence changes.

For the doctor, the final test is freedom with an accurate record. Michael can describe what he contributed, what he handed over and what he now undertakes. He is neither erased from the service's history nor required to remain its informal safety net. His pension choice, job plan, licence and personal priorities form one coherent later-practice arrangement, each governed by the correct source and open to review. That is the practical meaning of a sustainable SAS career: contribution made visible, choices informed, and responsibility held only where authority, time and present commitment remain.

The twelve-month plan should then become ordinary maintenance rather than a special retirement file. Place the next appraisal, pension-record check,

job-plan review, health or adjustment review, indemnity confirmation and succession check on one calendar. At each point ask whether the work being done still matches the work authorised and supported. If it does, preserve the evidence briefly. If it does not, reopen the relevant agreement while change is still possible. Later practice remains professional practice: bounded, evidenced, connected to others and capable of ending without confusion.