

Entering or changing an SAS post

Reading the advert critically

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

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

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

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

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

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

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

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

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

Testing the person specification

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

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

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

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

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

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

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

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

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

Job description and service reality

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

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

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

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

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

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

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

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

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

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

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

Contract and pay due diligence

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

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

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

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

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

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

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

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

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

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

Professional and immigration checks

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

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

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

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

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

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

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

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

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

Induction supervision and named support

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

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

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

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

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

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

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

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

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

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

The first job plan and portfolio plan

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

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

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

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

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

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

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

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

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

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

First ninety days

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

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

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

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

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

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

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

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

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

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

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