

Competing for Specialist posts in England and Northern Ireland

Competitive appointment and employer created posts

Priya and Omar are composite doctors. Both have worked for more than twelve years after their primary medical qualifications, and both have substantial NHS experience. Priya is a Specialty Doctor in England. She manages a defined group of complex patients autonomously within the service's governance arrangements, leads a recurring quality meeting, teaches several professional groups and has evaluated a change that she helped introduce. Omar is a Specialty Doctor in Northern Ireland. He has worked just as long, is highly trusted clinically and regularly keeps the service functioning when senior colleagues are absent. When similar Specialist posts are advertised, each assumes that long service will be the central proof of readiness.

It is not. Length of service supplies context, but an advertised Specialist post is filled through a competitive appointment process. The employer first decides to establish a post with a particular scope, resources and person specification. Eligible applicants then have to show that they meet the stated requirements and are the strongest appointable candidate under the employer's process. A doctor can already be practising at considerable seniority yet not be entitled to an uncreated post, automatic shortlisting or appointment. Conversely, a vacancy may be designed around a narrower defined area of practice than the doctor expected. The title alone cannot settle the match.

Three decisions must remain separate. The first is appointment to the employment grade called Specialist under the applicable national contract. The second is entry onto the GMC Specialist Register, which may follow an approved training route, the Portfolio Pathway or another recognised route. The third is regrading or progression under a national policy in Wales or Scotland. England and Northern Ireland do not acquire the Welsh or Scottish policy simply because all four nations use the word Specialist. A doctor may be appointed to a Specialist-grade post without being on the Specialist Register if the vacancy and person specification permit it. Specialist registration, discussed in Chapter 18, does not itself create or confer an NHS Specialist-grade job. [99][5]

The distinction changes preparation. If Priya wants the advertised employment post, her governing document is the live recruitment pack: advertisement, job description, person specification, proposed job plan and employer instructions. The national Specialist capabilities help her interpret the level expected, but they do not replace local criteria. If she wants specialist registration, the live GMC curriculum and specialty-specific guidance organise the evidence. If she wants a Welsh or Scottish regrading route, the operative national policy governs eligibility and process. One portfolio may provide material for all three destinations; it must be selected and explained differently for each.

Do not begin by asking whether you are ‘basically already a Specialist’. Begin with four concrete questions. Does an actual post exist? Which national contract is offered? What work has the employer defined? What evidence will its panel assess? This approach protects the doctor from two opposite errors. The first is self-exclusion because a colleague says the role is ‘consultant level’ without analysing the actual specification. The second is overconfidence based on title, years or informal praise when an essential criterion remains unsupported.

The employer’s design also deserves scrutiny. A genuine Specialist role should reflect a senior, independent or autonomous practitioner working within defined competencies and local clinical governance. It should not be a vaguely enlarged Specialty Doctor post carrying additional liability without corresponding authority, time or resources. Equally, the grade is not a device for renaming every experienced doctor. The post needs a coherent specialised scope and a person specification that identifies which capabilities are key at entry and which may be developed after appointment. National materials were constructed to help employers make that judgement rather than copy an undifferentiated list into every vacancy. ^[6]

Priya therefore treats the vacancy as both an opportunity and a proposal to be tested. Omar does the same. They ask what problem the organisation is trying to solve, which decisions the postholder will own, how the work connects to consultants and other senior clinicians, and what success would look like after a year. This is not suspicion. It is professional due diligence. A candidate can prepare a better application when the role is intelligible, and a service is more likely to appoint well when it can explain the role beyond the grade name.

The national capability framework

The generic capabilities framework begins with the role’s core idea: the Specialist doctor provides expertise in a specialised area, whether in a

specific specialty or a generalist service, and can manage the full range of presentations in that defined area of practice. The final phrase matters. It does not require the breadth of every consultant post in an entire specialty, but it does require more than a collection of selected tasks performed only when others are immediately available. Scope and autonomy have to be defined together. ^[6]

The framework groups capability across professional values, skills and knowledge; leadership and teamworking; patient safety and quality improvement; safeguarding; education and training; and research and scholarship. These are not six decorative headings for an application. They describe different forms of work. Clinical expertise concerns assessment, judgement, management, uncertainty and recognition of limits. Leadership concerns decisions, relationships, challenge and adaptation. Quality concerns action on risk, improvement cycles and learning. Education concerns creating and evaluating learning, not simply delivering slides. Scholarship concerns appraisal and use of evidence, not necessarily possession of a research degree.

Translate each domain into a claim-evidence pair. For clinical judgement, identify the population and setting, the decisions made, boundaries of competence, access to help and evidence from actual practice. For teamworking, choose an example in which professional differences mattered and show how you obtained a decision or safer plan. For quality improvement, retain the baseline problem, your contribution, the change tested, results and what happened afterwards. For education, distinguish teaching attendance, teaching delivery, supervision, assessment and programme leadership. For scholarship, show how evidence altered practice or informed a decision rather than listing journal articles read.

Capability is demonstrated at the relevant level through several forms of evidence. The national person-specification template gives examples including job plans, logs, audit of personal practice, colleague references, appraisal and job-planning evidence, feedback, quality work, teaching records and interview. It also makes a crucial distinction: some capabilities need to be fully present and evidenced at appointment, while others may be developed in the role. Employers should identify what is key for the particular post and what is required but not key. Candidates should therefore resist both extremes—assuming every framework statement must be separately proved in identical depth, or assuming a generic statement of seniority covers them all. ^[100]

Use the framework as a diagnostic map before applying. Mark each capability in one of four states: directly required by the vacancy and strongly

evidenced; required but evidence needs preparation; prospectively developable under the specification; or apparently irrelevant or unclear. The last category requires clarification rather than silent deletion. A service may omit formal research leadership but still expect critical use of evidence. It may require supervision without specifying whether educational-supervisor recognition is essential at entry. The candidate needs to know what the wording means in that employer's process.

Evidence should show level as well as participation. A certificate from a leadership course records learning activity. It does not prove that the doctor led a difficult service decision. Minutes naming the doctor as chair may prove presence and role, but not the quality or effect of leadership. A concise account can bring several records together: what responsibility Priya held, the competing interests, the decision she made or influenced, the result, what she learnt and how this prepares her for the advertised responsibility. The underlying documents should support rather than merely decorate that account.

Autonomy must also be described safely. The framework recognises senior independent or autonomous practice within defined competencies and local governance. No responsible senior doctor works without boundaries, collaboration or escalation. A candidate who says 'I never need help' demonstrates poor judgement, not independence. Strong evidence identifies when the doctor acted without routine supervision, how complexity was managed, when advice was sought, and how the system made escalation available. The same description helps a panel distinguish mature autonomy from unsupported lone working.

The capabilities overlap, but do not collapse them into a single heroic story. Priya's pathway project may demonstrate clinical reasoning, multidisciplinary leadership, patient involvement, improvement and teaching. She should make her contribution clear and cross-reference the project where the application permits, while retaining other examples. One project rarely demonstrates the full range of a senior role. Panels need confidence that capability is sustained across ordinary work, not confined to the candidate's most successful month.

An honest gap does not always end an application. Read the vacancy wording. If a capability is desirable, or explicitly intended for prospective development, show adjacent experience and a credible plan. If it is essential at appointment, do not relabel potential as completion. Contact the named person before the deadline where interpretation is genuinely unclear. A short, specific enquiry about the criterion is more useful than asking whether the candidate is 'senior enough' in general.

Omar discovers this when the Northern Ireland template identifies educational capability but the local job description emphasises clinical supervision rather than formal educational supervision. He has observed and supported doctors in practice, provided feedback and escalated concerns, but he is not a recognised educational supervisor. His application states precisely what he has done. Before applying, he asks whether formal recognition is an entry requirement or planned development. He neither hides the gap nor allows an ambiguous phrase to exclude him without clarification.

The capability map should end with an action, not a colour-coded impression. For each weak essential criterion, decide whether the evidence exists, needs authorised preparation, needs independent confirmation, or represents experience not yet obtained. The first three may be resolved before the deadline. The fourth may justify an application only if the criterion is developable; otherwise it belongs in the longer plan from Chapter 14. The map is valuable because it tells the truth early enough to influence a decision.

Reading the job description and person specification

Read the complete recruitment pack twice. On the first pass, understand the service. On the second, create an assessment map. Save the version and date because pages can be amended or removed after the closing date. Do not rely on an online summary copied into an alert. The detailed documents determine the duties, entry criteria and evidence expected.

Start with scope. Name the patient group, pathways, sites, procedures and interfaces for which the postholder will be responsible. Ask whether ‘full range’ refers to a defined service area or the whole specialty. Identify exclusions and referral arrangements. If the description moves between broad specialty language and a narrow clinic without explanation, seek clarification. An applicant can meet a well-defined specialised scope without reproducing every aspect of consultant training; an unclear scope makes both application and later governance unsafe.

Next examine autonomy and accountability. Which clinical decisions will the postholder make? Is there named consultant input, peer support or cross-cover? Who holds service-line accountability? Will the Specialist lead a team, supervise doctors, authorise pathways or chair governance? Phrases such as ‘work independently’ and ‘support the consultant’ can coexist, but the practical relationship must make sense. Independence within competence is compatible with collaboration. Accountability becomes

hazardous when the doctor is expected to carry a result without the authority, staffing or information needed to achieve it.

Map the working pattern. Look for sites, programmed activities or sessions, predictable and unpredictable emergency work, out-of-hours commitments, travel, administration, supporting activity and flexibility clauses. A sample timetable may be illustrative rather than agreed. Compare it with the narrative duties. If the role includes service improvement, supervision, appraisal responsibilities or teaching, locate the time assigned to those functions. An attractive leadership paragraph that has no place in the proposed week may represent aspiration rather than a deliverable job.

Study the essential and desirable criteria line by line. Essential means the employer expects the criterion to be satisfied for appointment, although its method of assessment may differ. Desirable criteria can distinguish candidates but should not be treated as invisible essentials after applications close. Record where each criterion will be assessed: application, reference, interview, presentation, occupational or pre-employment check. If the document does not state this, prepare evidence for the written application and interview while keeping within the form's instructions.

Qualifications require exact reading. The employment grade is not the same as the Specialist Register, so do not assume registration is mandatory unless the vacancy says so and the requirement is lawful and relevant. Equally, do not assume that years after qualification automatically satisfy the employer's entry wording. Check the live person specification, the applicable national template and any specialty-specific requirement. If a criterion appears internally inconsistent—for example, the advertisement welcomes SAS applicants while the form asks for registration not normally required for the grade—raise it promptly with recruitment and retain the response.

The national entry wording includes full GMC registration with a licence and at least twelve years' medical work after primary qualification, of which at least six years should be in a relevant specialty in Specialty Doctor or closed SAS grades; equivalent relevant experience from other grades, including overseas, is also accepted. Apply the live vacancy wording and prove dates rather than rounding them. [99][5]

Test each leadership statement for authority and resource. 'Lead development of the service' could mean designing and implementing a defined pathway with access to data and a reporting line. It could also mean being held responsible for vacancies and waiting lists without budgetary or managerial authority. Ask which decisions belong to the doctor, which require approval, who provides project and analytical support, and how

objectives will be agreed. The answer affects both willingness to apply and the examples to foreground.

Quality and governance need the same scrutiny. Identify expected meetings, incident-review work, audit or quality-improvement responsibilities, guideline ownership, complaints contribution and duty to raise concerns. Ask how data will be provided and who owns organisational risks. A Specialist doctor should participate actively in governance, but an employer cannot make every system failure an individual medical duty through a broad sentence. The post should sit in a defensible governance structure with escalation routes.

For education, distinguish bedside teaching, clinical supervision, educational supervision, assessment, faculty work and programme leadership. Each requires different preparation and evidence. If the post will supervise doctors in training, ask what recognition, training and time are expected under the local framework. If the role covers LEDs, students or other professionals, clarify reporting and escalation. A candidate's enthusiasm for teaching should not be used to create an unlimited unpaid function after appointment.

Check practical resources before interpreting the role as an advancement. Does it have appropriate workspace, administrative support, IT, access to data, continuing professional development and study leave, mentorship or peer connection? How is cover arranged for leave? Does the service expect cross-site travel within the proposed timetable? A senior title cannot compensate for a design that makes safe delivery improbable. These questions can be asked professionally and in stages; they need not all be posed as objections in the first telephone call.

Finally, identify the service problem beneath the paperwork. Review the organisation's published strategy, relevant quality information and any material supplied by the recruiting team. Ask the clinical contact what the successful candidate should have achieved at six and twelve months. Listen for alignment between that answer and the job description. A panel presentation often concerns service development. Understanding the real problem allows a candidate to propose a measured first step instead of promising a transformation without resources.

The vacancy analyser can be set out in ten rows: defined scope; clinical autonomy; boundaries and escalation; leadership authority; quality responsibilities; education; research and scholarship; working pattern; resources; and first-year outcomes. For every row record the source wording, your interpretation, a question requiring clarification, and one relevant evidence example. Add a final decision—apply now, seek

clarification, or do not apply—with reasons. This turns a promotional document into a professional decision.

England source set

For an England post, begin with the current NHS Employers Specialist terms and conditions, model contract, generic capabilities framework, appointment guidance and person-specification materials. Then place the employer's live recruitment pack above them for vacancy-specific criteria. The terms establish the national employment architecture; the capability and appointment materials support role design and recruitment; the vacancy states what this employer is actually seeking. None should be replaced by recollection of a neighbouring trust's process. [99][101]

The Specialist role was introduced within the 2021 SAS contract reform. The national concordat supported the creation of appropriate Specialist roles and a consistent method for appointments. That history helps explain why vacancy numbers and designs differ between organisations. It does not create an individual entitlement to promotion after a certain number of years. Employers need to identify service need and establish posts; candidates then compete under the published process. If local practice seems inconsistent with national materials, a candidate or staff representative can raise the specific discrepancy without assuming the appointment outcome.

England also introduced an SAS Eligibility and Permanency Framework in 2026, with applications opening on a rolling basis from September 2026. It concerns eligible locally employed doctors whose duties and responsibilities are comparable with national SAS roles and provides a process for movement to an appropriate permanent national contract. It should be date-labelled and read in full by anyone relying on it. It is not the same as open competition for a newly advertised Specialist post, and it is not a generic Specialty Doctor-to-Specialist regrading policy. An LED may need the framework to establish the appropriate national contractual destination; an existing Specialty Doctor considering a Specialist vacancy still follows the vacancy and appointment process. ^[102]

This distinction matters when colleagues use 'transfer', 'conversion' and 'progression' interchangeably. Ask what is changing: employer, contract, grade, duties, or regulatory status. A doctor moving from a local contract to nationally recognised terms may gain permanency and contractual clarity without obtaining Specialist registration. Whether the appropriate SAS grade is Specialty Doctor, Specialist or a closed legacy grade depends on the framework's criteria and evidence, not on the doctor choosing the most senior label. Because the framework is new and operational detail may

evolve, check the live joint guidance and local implementation before acting.

Recruitment equality and organisational policy also apply. Follow the employer's instructions about reasonable adjustments, supporting statements, values evidence and declarations. If a candidate needs an adjustment, request it through the stated route early enough for the employer to arrange it. Do not dilute relevant evidence in an attempt to avoid discussing an adjustment. Selection should assess the stated requirements using an accessible process, while occupational-health questions and adjustments have their own appropriate timing and confidentiality.

Where an England pack is unclear, ask the named recruitment contact to identify the current version of the terms, person specification and proposed job plan. A trade union or professional adviser can help interpret contractual points. The aim is not to turn every application into a dispute. It is to ensure that the candidate knows which grade is offered, which standards apply and what they are being asked to accept.

Northern Ireland source set

Northern Ireland has its own published SAS 2021 contract documentation. The Department of Health collection includes the Specialist terms and conditions, model contract, generic capabilities framework, concordat, notes on the person-specification template and a Northern Ireland template. These documents should be used directly for a Northern Ireland appointment rather than assuming that an England webpage is operative. The broad capability architecture is shared, but the contract, employer structures and current pay circulars belong to the jurisdiction.^[5]

The Northern Ireland person-specification template explains how employers should identify capabilities that are key for the post and those required but not key. It gives examples of evidence and identifies several capabilities expected to be tested at interview because of the level of clinical responsibility and autonomy. It also recognises that some capability may be developed prospectively and then assessed through later appraisal. The candidate should examine how the employing trust has adapted the template, not submit a generic response to the national list.^[100]

Omar's vacancy is in a defined generalist service. The phrase 'specialised area' therefore does not mean a narrow procedural subspecialty. The national framework expressly allows expertise in a specialised area within a specific specialty or a generalist service. Omar maps his evidence to the actual presentations, uncertainty and service interfaces described in the pack. He does not claim the breadth of an unrelated tertiary role, and he does

not apologise for generalist expertise. The question is whether he can manage the full range within the defined practice area at the required level.

Northern Ireland's concordat and capability materials assist services to establish roles, but they do not remove workforce constraints or local approval. A candidate may hear that a department supports a Specialist post but cannot yet advertise it. That is a workforce discussion, not a selection outcome. Preserve any agreed development plan, continue to make work visible through job planning and ask for realistic timescales, but do not write an application to an imaginary vacancy. When a post is published, start again from its final documents because scope and criteria may have changed during approval.

Pay and contractual details should be checked against the current Northern Ireland terms and pay circular at the point of offer. The model contract is useful for structure, but the actual written offer and statement of particulars need careful review. If prior experience is said to affect starting salary, ask the employer to explain the basis and provide the decision in writing. Do not assume that the England pay table or a colleague's outcome transfers automatically.

The same applies to work schedules, out-of-hours arrangements and job-planning mechanisms. The role may be clinically similar across the Irish Sea while contractual language and local process differ. Omar separates questions for the panel—about service and expected capability—from questions for medical staffing and his adviser about terms. This prevents an interview from becoming an improvised contract negotiation while ensuring that consequential matters are not forgotten after a verbal offer.

If the recruitment pack uses an obsolete label or appears to mix Specialist with Associate Specialist, seek written clarification. Associate Specialist is a closed legacy grade; Specialist is the newer national grade. Similar seniority in everyday speech does not make the contracts interchangeable. A candidate should know exactly which national terms, pay scale and job-planning provisions are proposed before accepting.

Building the written application

The written application is an evidence map expressed in prose. Begin with the essential criteria, not the chronology of your career. Create a working table with one row per criterion and five columns: requirement; strongest example; supporting record or witness; result and learning; relevance to this post. Only then draft the form. This protects the application from becoming a long biography in which the panel has to search for answers.

Use a responsibility-action-result-learning-relevance sequence. Responsibility explains what you were accountable for and the setting. Action identifies your decisions and contribution. Result reports what changed, including uncertainty or incomplete outcomes. Learning shows reflection and adaptation. Relevance connects the example to the advertised role. The sequence is not a rigid acronym to recite in interview. It is a check that each example demonstrates more than attendance.

Priya's strongest improvement example concerns delayed follow-up of investigation results in a composite service. She did not 'single-handedly redesign the pathway'. Her application says that she identified a recurrent risk through governance review, agreed a project scope with the multidisciplinary team, analysed an authorised aggregate baseline, led a small test of a revised allocation process, and returned with follow-up data. The measured delay reduced during the test, but one site did not sustain the change. She explains what she learnt about ownership and monitoring and how she would establish the advertised post's governance work. The account is credible because its verbs match the records.

Omar initially writes: 'I have vast experience of managing complex patients independently.' He revises this into a defined example. He describes the service population, a difficult decision under uncertainty, the information available, how he involved the patient or family, when he sought specialty advice and how follow-up was arranged. He preserves confidentiality and does not submit patient records to recruitment. The example shows the judgement, boundaries and communication that 'autonomous' is meant to convey.

Select a spread of evidence. One clinical case can demonstrate judgement but not sustained service leadership. One audit can show analysis but not necessarily implementation. One positive reference cannot establish every criterion. Aim for complementary examples across clinical practice, team leadership, safety and improvement, education and evidence use. Where the form limits words, mention a second example briefly or reserve it for interview. Repetition wastes space and makes the portfolio appear narrower than it is.

State your role in collective work. Senior NHS achievements are almost always shared. Panels do not require a solitary hero; they need to understand the candidate's contribution. Use 'I' for your decisions and 'we' for the team's work. If the project had an executive sponsor, data analyst, nurse lead and patient partner, say so where relevant. Giving credit increases rather than reduces credibility. It also demonstrates the collaborative leadership expected of the grade.

Address every essential criterion explicitly. If one example covers two criteria, tailor the explanation to each or cross-reference only where the form permits. Do not make a panel infer a qualification, licence status or experience from the CV when the application asks for confirmation. Check dates and names across the employment history, supporting statement and declarations. An unexplained discrepancy may distract from a strong application and can delay checks.

For desirable criteria, show relevance rather than accumulating labels. A postgraduate qualification matters if it supports the role's practice, education or service development. A publication matters if it shows scholarship useful to the work. Committee membership matters if the candidate contributed to decisions and can describe an outcome. Prestige without connection uses words that should have been spent on evidence.

Handle gaps openly but proportionately. If formal educational-supervisor recognition is desirable and you are enrolled for the required development, say what you have already done, the current status and the expected completion date without presenting it as achieved. If an essential criterion is missing, seek clarification before applying; do not disguise it. A shortlisting panel may reject the application, and a misleading assertion creates a more serious professional issue than honest non-appointment.

Avoid confidential detail. Recruitment evidence should be anonymised and authorised for use. Describe the clinical or governance problem at the level needed to show judgement. Do not attach patient records, incident-system screenshots or confidential investigation papers unless the employer's process expressly requires an appropriately handled document and you have confirmed the lawful route. A panel normally needs a truthful account and suitable organisational evidence, not access to the underlying patient file.

The personal statement should answer three questions: why this role, why this service, and what evidence shows readiness. Replace generic admiration for the organisation with a concrete connection to its published need. Explain the specialised contribution you can make, the first issues you would need to understand and the boundaries of what can be promised before appointment. Confidence is compatible with conditional language where resources and baseline data are not yet known.

Before submission, conduct a cold-reader test. Give the person specification and draft to a trusted colleague who did not work on the examples. Ask them to underline where each essential criterion is evidenced and to state what they think your contribution was. If they cannot find it, the panel may not find it. Correct ambiguity rather than adding adjectives. Then

proof dates, qualifications, registration, referee details and declarations against source records.

The final criterion matrix should remain after submission. Add the exact paragraph or example used, likely interview question and one reserve example. This becomes the interview plan. Priya's matrix shows strong evidence across most domains but only a modest research claim. She does not manufacture research leadership; she explains critical appraisal and implementation of evidence relevant to the role. Omar's map shows sustained clinical capability but less formal service evaluation, so he prepares a careful account of what he has contributed and what support he would seek in the new post.

References and pre interview due diligence

Choose referees who can comment on the work most relevant to the post and who meet the employer's instructions. Senior title alone is insufficient if the referee has little direct knowledge. Speak to each proposed referee before submitting, confirm contact details, provide the current job description and remind them of the examples they directly observed. Do not script praise or ask someone to certify work they did not see. A specific, accurate reference is more valuable than a prestigious but generic endorsement.

If the employer requests the current or most recent line manager and you have a reason for proposing another referee, follow the form's route and explain it appropriately. Do not omit a required employment relationship silently. Concerns about confidentiality, conflict or an ongoing process should be discussed with recruitment or an adviser. The purpose is to meet the process while ensuring that information is accurate and relevant.

Pre-interview due diligence is an active professional conversation. Arrange contact with the named clinical lead and, where offered, a visit or virtual discussion. Ask what led to creation of the post, how its scope was determined, what the team expects in the first year, which resources are agreed and what remains under development. Listen for differences between the job description and operational reality. Record factual answers for your own preparation, but do not treat an informal conversation as a contractual promise.

Ask how clinical autonomy works at difficult boundaries. Which cases remain within the Specialist's scope? What advice is available outside normal hours? Who covers absence? What happens when demand exceeds capacity? How are disagreements escalated? These questions demonstrate mature judgement when asked constructively. A candidate should be wary of a role described as fully autonomous only when the service wants

someone to absorb risk, but closely controlled when the doctor needs authority to improve it.

Examine the proposed job plan. Identify direct clinical care, supporting professional activity, leadership, education, travel and on-call. Ask which elements are fixed, what can be negotiated after appointment and how the initial plan will be reviewed. If significant work is expected but unscheduled, raise it. The first job plan should make the role deliverable, not rely on the new postholder donating evenings to justify the grade.

Clarify the team and infrastructure. Ask about vacancies, administrative support, data access, supervision responsibilities, relationships with consultants and other Specialists, and current improvement priorities. Where the post crosses sites or organisations, ask how accountability and information flow are arranged. A candidate cannot calculate every future difficulty, but can identify whether the organisation understands the design it is recruiting into.

Interview and presentation

Prepare by capability and criterion, not by guessing a list of questions. Build an interview bank covering clinical judgement under uncertainty, recognising limits, multidisciplinary conflict, patient-centred communication, raising concerns, quality improvement, leadership, education, use of evidence, equality and values, and service development. For each area, prepare a primary example, a shorter reserve and the lesson that will alter your future practice. The examples should come from real professional work presented without identifying details.

A strong answer makes the decision visible. Set the context briefly, state your responsibility, identify the competing considerations, explain the action and result, then reflect. Do not spend most of the answer describing the organisation. If the outcome was imperfect, say what remained unresolved and what you changed. Panels often learn more from a candidate who can analyse a limited result than from one whose every story ends in triumph.

Clinical scenarios test method as well as knowledge. Establish immediate safety, obtain relevant information, involve the patient and team, recognise limits, escalate appropriately, document and arrange follow-up. The exact clinical response depends on the specialty and scenario. The seniority signal is not maximal certainty; it is structured judgement that can operate under uncertainty while preserving accountability. If information is missing, state what you need rather than inventing it.

Governance scenarios need a similar sequence. Describe how you would contain immediate risk, preserve facts, use the relevant reporting and escalation route, support those affected, and contribute to learning without prejudging a formal investigation. Distinguish individual action from system responsibility. An answer that promises to ‘deal with’ a colleague alone may overlook process, fairness and patient safety. An answer that sends every issue upwards without taking any action may not demonstrate Specialist leadership.

For leadership questions, avoid title-based claims. Explain a situation in which you had to align people who did not report to you, challenge a proposed course or sustain a change after initial agreement. Identify power and constraints. Say how you sought dissent, what you decided and how the decision was communicated. If the project depended on senior approval, be clear. Influence within governance is not diminished by acknowledging where formal authority sat.

Education questions should move beyond enjoyment of teaching. Describe how a learning need was identified, what you designed, how you adapted for the learner or team, what feedback was obtained and what changed. If the role involves supervision, be ready to discuss boundaries, documentation, learner safety and escalation of concern. Do not claim formal educator status from informal mentoring. Explain current recognition and development accurately.

A presentation is a test of prioritisation. Confirm the title, duration, audience, equipment and whether questions are included. Define the service problem before proposing a solution. Use available evidence, state assumptions and distinguish actions the postholder can initiate from decisions requiring organisational approval. A practical structure is: problem and why it matters; what must be understood in the first ninety days; one or two feasible tests; measures; stakeholders and risks; and what a twelve-month review would examine.

Do not promise results that depend on resources you have not seen. ‘I will eliminate the backlog in six months’ may sound energetic but reveals weak due diligence. A better answer identifies baseline demand and capacity, patient-risk stratification, process mapping, staff involvement, a testable change and balancing measures. Explain what would cause you to stop or modify the intervention. This shows that improvement is governed work, not a slogan.

Prepare questions for the panel that follow from the role. Ask about first-year priorities, governance, authority, job-plan review, team development and support. Avoid asking only what is already clear in the pack.

Contractual detail can be confirmed with medical staffing after a conditional offer, but a material ambiguity about role scope should be resolved before you decide whether appointment is acceptable.

Priya and Omar now diverge. At Priya's interview, she uses a concise range of evidence. She explains autonomous clinical work without denying the value of consultation, shows a quality project including its partial failure, and presents a measured first-year plan. Omar relies mainly on length of service and repeated assurances that everyone trusts him. His clinical answers are sound, but the panel cannot identify his personal contribution to governance or how he would establish the new service responsibilities. Similar years have produced different assessable evidence.

This comparison is not a moral judgement. Omar may be equally capable in daily practice. The appointment process can assess only what is relevantly demonstrated through the permitted methods. His next step is not another decade of service. It is to define scope, obtain proportionate evidence, create opportunities to demonstrate missing domains and practise explaining decisions. The result illustrates why evidence maintenance in Chapters 12 and 14 is career infrastructure rather than self-promotion.

After interview, write down the questions, your answers and any new information about the role. If unsuccessful, request feedback under the employer's process. Separate criterion-based feedback from vague commentary, compare it with your evidence map and decide what action is justified. A single panel decision is not an authoritative verdict on an entire career. Equally, dismissing every disappointment as predetermined prevents learning. Look for a specific gap, communication problem or mismatch and seek advice if the process itself appears materially flawed.

Offer and first Specialist job plan

A verbal indication is welcome but incomplete. Wait for the conditional written offer and complete the required checks. Confirm the employer, grade, national contract, salary basis, hours or programmed activities, base, on-call, start date, probation if any, leave, notice and pre-employment conditions. Compare these with the advertisement and discussion. Where wording differs, ask for clarification before resigning from an existing post or treating the appointment as final.

Salary placement should be explained under the applicable national terms and current pay arrangements. Provide requested evidence of reckonable experience, but do not infer the outcome from another doctor's appointment. Ask for the calculation or decision in writing and obtain contractual advice if

necessary. Pay is important, yet the value of the role also depends on job-plan realism, authority, support and long-term sustainability.

Use the proposed job plan as an operating agreement. List the clinical duties, leadership, governance, education, administration, continuing professional development, on-call and travel that the role actually requires. Attach realistic outputs and dependencies to major objectives. If the service expects the new Specialist to develop a pathway, identify data, managerial support, stakeholder authority and time. A title does not create these resources.

Agree boundaries and escalation early. Record the defined area of autonomous practice, access to advice, cross-cover and how new duties will be introduced. This is particularly important when appointment recognises some existing capability but the job adds unfamiliar responsibilities. Development after appointment should be planned, supervised where needed and reviewed. The national person-specification approach allows some capabilities to be developed prospectively; this must become a real plan rather than an assumption that the postholder will learn invisibly while carrying full responsibility.^[100]

Set a first-year evidence plan. In the first month, confirm scope, governance contacts and baseline priorities. By three months, review whether the job plan reflects actual work and whether agreed resources are available. By six months, examine early objectives, development and team relationships. By twelve months, evaluate results and revise the plan. These are practical review points, not universal contractual deadlines. Use the formal job-planning and appraisal mechanisms applicable to the contract.

The offer checklist therefore asks: Is this definitely the Specialist grade under the correct national terms? Is the scope defined? Are authority and accountability aligned? Is all expected work scheduled? Are support, cover and data identified? Is salary placement explained? Are prospectively developed capabilities named with support and review? Is there a safe route to raise a mismatch? Does the post still serve the destination chosen in Chapter 14?

Priya accepts only after these questions are answered. Her appointment does not place her on the Specialist Register and she does not describe it that way. It does establish a new employment role with a defined scope, national terms and explicit responsibilities. Omar uses his feedback to rebuild the evidence record and seek opportunities linked to the next suitable vacancy. Neither outcome is automatic reward or permanent judgement. Both are decisions that can be understood and acted upon.

Before any later application, refresh every source. England's 2026 Eligibility and Permanency Framework, national pay arrangements and local recruitment systems can change. Northern Ireland's terms and pay circulars can also change. Keep the source date beside the decision. The enduring method is to identify the destination, read the live documents, map evidence to criteria, test the role, and accept only after the work and contract are intelligible.