ISC MEDICAL

2026-27 EDITION

THE CONSULTANT INTERVIEW HANDBOOK

From being appointable
to becoming the preferred candidate



Evidence. Judgement. Confidence.

A practical, in-depth companion to the ISC Medical Consultant Interview Course. For doctors preparing to explain their experience, lead people and services, and demonstrate the judgement expected of a consultant.

23 chapters | Six course mock interviews | Specialty reading guide

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A handbook to use, not memorise

The aim is not to know the most facts in the room. It is to make your experience, judgement and contribution clear.

Becoming a consultant is a change in responsibility, not simply a new job title. The panel needs to understand how you will care for patients, work with colleagues, support others and contribute to a service. This handbook helps you select and explain the evidence for those responsibilities.

Use the chapters according to your needs. Read the appointment and communication chapters first. Develop your own examples with CAMP, STAR, CPR and SPIES. Then use the chapters on values, visits, presentations, leadership and governance to deepen your preparation. Consult NHS topics selectively rather than trying to memorise every policy.

PREPARE YOUR EVIDENCE	UNDERSTAND THE ROLE	MAKE IT YOUR OWN
CAMP, STAR, CPR and SPIES, with thematic examples and reflection.	AAC panels, values, leadership, governance and NHS priorities.	Worked cases, presentations, pre-interview visits and preparation worksheets.

Before the course

Read Chapters 1-5 and gather the job description, person specification and a small bank of genuine examples.

After the course

Use the relevant teaching chapters to work on the feedback you received. Rehearse aloud and make the evidence more specific rather than simply making answers longer.

Before the interview

Complete the Chapter 20 worksheets selectively. Use Chapter 21 for the six course mock interviews, and Chapter 22 to select national and specialty reading. Rehearse aloud and practise adapting your evidence.

About the examples

Practice cases, sample statements and scoring grids are educational illustrations, not scripts, official marking schemes or accounts of named patients. Never invent personal experience. Use truthful examples, protect confidentiality and recognise the limits of your evidence.

This handbook includes guidance for England, Wales, Scotland, Northern Ireland and the Republic of Ireland. Appointment arrangements, healthcare structures and policies differ between countries. Use the relevant country guidance and check the current requirements of the organisation you are applying to. The reading guide identifies publication scope and dates; local recruitment information and professional obligations take precedence over generic advice.

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01
The consultant appointment



Understand the role, the recruitment journey, the AAC and the distinction between being appointable and being appointed.

01 Recruitment and AAC | 02 Suitability and selection | 03 Understanding assessment

1.1 What changes when you become a consultant?

The panel is not merely deciding whether you are a good senior registrar, associate specialist or locum. It is deciding whether to appoint a colleague who can be trusted with an ongoing senior role. That means balancing professional competence with responsibility for people, systems, standards and outcomes. It also means understanding that consultants work within teams and organisations: independence is not the same as autonomy without accountability.

A convincing candidate demonstrates breadth, depth and judgement. Breadth means appreciating the clinical, educational, organisational and interpersonal dimensions of the post. Depth means bringing credible, specific evidence rather than relying on labels such as “I am a natural leader”. Judgement means being proportionate: knowing when to act, when to consult, when to escalate and when to listen.

A useful way to picture the transition is to think of four overlapping roles. You are a senior professional delivering high standards of care within your competence; a leader of people, shaping culture and supporting colleagues; a steward of a service, balancing safety, access, outcomes and finite resources; and a member of the organisation, contributing to strategic priorities beyond your immediate clinical interest.

What an excellent answer demonstrates

Even when the question sounds personal or technical, the panel may be listening for some combination of maturity, self-awareness, patient focus, respect for others, realistic planning and willingness to learn. An answer about service development should therefore acknowledge stakeholders and capacity. An answer about leadership should demonstrate influence and impact. An answer about your career should connect achievements to what this department needs next.

PREPARATION PROMPT

> Finish the sentence: “As a consultant, the difference I will make in this department is…” Write three versions: one about patient care, one about colleagues and one about service development. Check that each is realistic for the advertised job.

1.2 The recruitment journey: more than one interview

The process may involve an advertisement and application, evidence-based shortlisting against the person specification, pre-interview conversations or visits, stakeholder meetings, a formal panel, a presentation, and sometimes additional exercises. Some employers use psychometrics, group discussions or other assessments; others do not. The invitation and recruitment pack are the definitive sources for your own selection process.

Selection is often partly cumulative. Your written application provides evidence of eligibility, achievement and fit. Visits and informal conversations may help both sides understand expectations, although employers should assess candidates fairly and consistently. The presentation may reveal how you organise ideas and communicate to a mixed audience. The panel interview tests your reasoning and how you explain it under scrutiny.

A well-prepared candidate treats each stage as part of a coherent professional story. The same priorities, values and examples should recur naturally, without giving identical rehearsed answers. Do not assume that a friendly pre-interview visit guarantees an offer, or that every informal conversation carries a formal score.

Common formats

Element	What it may test	Preparation that helps
Formal interview	Suitability, values, evidence, judgement, contribution	Evidence bank; concise, specific answers
Short presentation	Prioritisation, structure, strategic thinking, communication	Clear message; timed rehearsal; purposeful slides
Stakeholder session	Collaboration, listening, relationships and local insight	Listen first; ask relevant, respectful questions
Group discussion	Influence, inclusion, ability to progress a shared task	Facilitate rather than dominate
Psychometric or leadership exercise	Preferences, behaviours, reflection and fit	Answer honestly; be ready to discuss examples

1.3 The AAC: who is sitting opposite you?

For relevant NHS trust appointments, the Advisory Appointments Committee (AAC) is a formally constituted panel. The consultant appointment regulations, as amended, and associated good-practice guidance set out its role and core membership. The AAC determines which candidates are suitable and makes a recommendation to the employing organisation. It is therefore misleading to describe every consultant panel as an identical statutory AAC.

The regulated AAC normally includes a lay member, an external professional assessor appointed after consultation with the relevant college or faculty, the chief executive or permitted senior nominee, the medical or dental director or relevant equivalent, and a consultant from the employing organisation, normally from the specialty where available. University representation is required where the relevant teaching or research arrangements call for it. Additional membership and substitutes must meet the applicable rules; check the current recruitment guidance.

Foundation trusts are not bound by the consultant appointment regulations in the same way as NHS trusts, although many follow comparable principles and invite college assessors. Their processes remain subject to fair recruitment, employment law and local policy. Some interviews may also include nursing or allied-health leaders, divisional managers, patient representatives and other stakeholders. For public-health consultant appointments and appointments outside England, seek the relevant specific guidance. Chapter 23 explains the local context for Wales, Scotland, Northern Ireland and the Republic of Ireland; do not assume that an English AAC description determines another jurisdiction's recruitment arrangements.

Understand each perspective

Panel perspective	What they may particularly care about
Lay chair / non-executive	Trust, values, public accountability, patient experience, organisational reputation
Chief executive / senior executive	Strategic fit, delivery, collaboration, resources, long-term contribution

Panel perspective	What they may particularly care about
Medical director	Professional standards, quality, governance, credibility and safe senior practice
Specialty consultant	Working relationships, service need, resilience, clinical scope and practical teamwork
External college/faculty assessor	Suitability for the consultant role, professional competence and fairness of process
University representative (where applicable)	Education, scholarship, supervision, research plans and academic contribution
Other stakeholders	Inclusion, interprofessional cooperation, patient voice and operational realities

These are perspectives, not fixed question allocations. Do not try to tailor a response so narrowly to one panel member that everyone else is excluded. Give an answer a mixed panel can understand, with enough substance to reassure the specialists.

1.4 How a decision is actually made

An AAC's core task is to assess suitability for appointment, not simply to choose the candidate with the warmest personality or the highest number of publications. The regulated AAC recommends suitable candidates; the employing body makes the appointment. It is possible for a panel to judge that none of the candidates meets the required standard. The precise sequence, record-keeping and local recruitment policy matter.

There is no universal NHS consultant interview marking sheet. Employers may use competency-based scores, anchored rating scales, written notes, panel consensus, moderation or combinations of methods. Interview questions and criteria should be relevant to the person specification and should be applied fairly. Never assume that an arbitrary five-point scale or majority vote is mandated everywhere. The old idea that every appointment is decided in an informal show of hands is too simplistic for current practice.

An illustrative assessment grid might consider: evidence relevant to the post; leadership and teamwork; quality and patient focus; strategic awareness; communication and professionalism; and the ability to reflect and learn. A panel may weight some areas differently. Below is a teaching example, not an official national rubric.

Illustrative rating	Meaning in practice
1 — Limited evidence	Little relevant substance; significant concerns or unclear response
2 — Developing	Some relevant points, but incomplete examples or limited insight
3 — Meets standard	Credible, relevant answer with clear evidence and sound reasoning
4 — Strong	Specific evidence, impact, reflection and good fit with the post
5 — Exceptional	Compelling contribution, mature judgement, distinctiveness and credible future value

The two decisions in the room

First, is this person appointable? That is about professional eligibility and whether the evidence meets the required standard. Second, why choose this candidate from among those who are appointable? That is where specificity, fit, priorities, evidence and the confidence you inspire become decisive. Your objective is not to collect as many “good” answers as possible; it is to leave a coherent picture of what it would be like to work with you.

A panel should guard against bias, stereotyping and unfair subjective criteria. Yet every conversation also creates a human impression. Strong preparation helps the panel understand your substance and reduces the opportunity for style to obscure it.

What does a score actually tell the panel?

There is no single national consultant-interview marking grid. Employers may use different competency domains, written score descriptors, weighting and processes. Some members score independently before discussion; others use agreed evidence standards and structured panel discussion. Candidates should therefore understand scoring principles, not memorise a supposedly universal scheme. The purpose of an assessment method is to make comparisons defensible and relevant to the person specification. The published recruitment information, rather than a generic example, is the authoritative guide for a particular post.

A strong answer makes it easier for several people to recognise the same evidence. If the question concerns service improvement, a vague response such as “I am passionate about innovation” offers little that can be scored. A response that identifies a problem, explains your decisions and engagement, shows measured or candidly limited impact and relates the lesson to the job provides specific evidence of insight, delivery and suitability. The most eloquent answer is not automatically the strongest one; content must match the assessed domain.

The panel's formal assessment and its interpersonal impressions can interact. Members may notice whether you listen, respond to challenges with composure, treat other professions respectfully and seem realistic about the local service. These impressions may influence judgements about teamwork, communication and leadership, but should not be treated as a secret extra marking grid. The safe preparation strategy is to be relevant, specific and genuine, while understanding that every answer also communicates how it may feel to work alongside you.

Example of an illustrative, not universal, marking rubric

Imagine a question asking how you would manage a disagreement over an elective pathway. At the weaker end, an answer may avoid the conflict, dismiss colleagues or offer no plan. A developing answer names a reasonable method but is generic. A stronger answer recognises the clinical and interpersonal dimensions, seeks evidence and views, identifies a proportionate decision process and explains how progress would be reviewed. An exceptional answer may also anticipate consequences, uncertainty, equity and wider service implications without losing clarity. These are examples of discriminating evidence, not a claim about the numerical scores used by NHS interview panels.

1.5 Feedback, unsuccessful outcomes and learning

A good interview does not guarantee an appointment. A role may have particular service requirements, competitors may offer different strengths, or an employer may decide not to appoint. Avoid judging your entire capability from a single result. Ask for concrete feedback on evidence, structure, examples, communication and priorities. Where possible, distinguish areas the panel felt were below standard from areas where another candidate simply offered a stronger fit.

After an interview, record the questions while they are fresh, note where you were drawn into excessive detail and identify which examples seemed effective. Do not endlessly reconstruct facial expressions or pauses: those observations are unreliable. If you are unsuccessful, use the experience to improve your preparation for the next, rather than memorising the answers you wish you had given.

1.6 Read the appointment process as an evidence exercise

The advertisement tells you that a vacancy exists. The job description explains what the organisation needs someone to do. The person specification describes the evidence against which candidates should be considered. Read these together. A broad statement such as "leadership experience" becomes much more useful when connected to a responsibility such as coordinating a cross-site pathway, supervising trainees or contributing to a service recovery plan.

Build a simple requirements map. For each important criterion, identify your best evidence, the particular responsibility it supports and any gap you need to address honestly. Do not assume that every desirable criterion is equally important, or that a very strong research record compensates for an essential requirement you cannot meet. Ask recruitment staff about eligibility or documentation rather than relying on a generic interview guide.

Formal assessments and informal conversations are different

A stakeholder panel, a presentation and a group exercise may form part of a declared selection process. A preliminary visit is different: the regulated appointment guidance says that such visits should not form part of selection and that candidates should not canvass support. Use visits to understand the role, not to obtain promises or preferential treatment. It remains sensible to behave professionally throughout, but that is not a reason to portray every conversation as a hidden scored interview.

For any additional exercise, establish its purpose and format. A meeting with patient representatives might explore listening and communication; a management discussion might explore priorities and feasibility. Neither is an invitation to give a clinical lecture. Adapt the language while keeping the same honest account of your experience and intentions.

Make evidence visible to a mixed panel

An external assessor may understand a technical achievement immediately. A lay member may need one sentence explaining why it matters. For example, replace a long description of a procedure with the patient benefit, the complexity of the decisions and your responsibilities. Technical detail can follow if requested. This does not dilute your expertise; it makes its significance available to everyone making the decision.

Avoid assigning stereotyped interests to individual panel members. A chief executive may care deeply about patient experience; a clinical colleague may probe finance; a patient representative may ask a demanding question about safety. Address the person asking, then include the rest of the panel naturally.

INTERVIEW INSIGHT

A score is not a count of impressive facts

A long answer can contain many facts and little usable evidence. When practising, ask someone to write down what the answer actually demonstrated: the decision you made, the behaviour you showed, the outcome and its relevance to this job. If they can record only job titles or activities, improve the explanation rather than adding another achievement.

Being eligible, being appointable and being selected

Keep these distinctions clear when interpreting an outcome. Eligibility concerns the requirements for the post and appointment. Being judged appointable means the panel considers you suitable under its process. Being appointed means you were selected and the appointment proceeds through the employer's arrangements. An appointable candidate who loses to another strong applicant has not necessarily failed to demonstrate consultant-level ability.

After an unsuccessful interview, ask for specific feedback against the assessed domains. Which examples lacked detail? Did you answer the question? Was there a particular development need? A comment such as "another candidate was stronger" needs unpacking before it can guide preparation. Do not reconstruct an entire performance from one panel member's facial expression.

02
Making your answers convincing



Communicate evidence and judgement while giving the panel confidence in you as a future colleague.

01 Evidence and judgement
02 Rapport and challenge
03 Clear, adaptable answers

2.1 Rational assessment and the emotional component

Panels should select fairly using relevant evidence. But interviewers are human beings, and their confidence in you develops throughout the interaction. They notice whether you answer the question, whether you listen, how you treat colleagues you mention, whether you acknowledge complexity and whether your examples feel genuine. A technically correct answer can still be unconvincing if it seems evasive, defensive, grandiose or detached from the organisation.

Think of two parallel processes. The analytical process asks, “Does this candidate demonstrate the required capabilities?” The interpersonal process asks, “Would I trust this person with a difficult issue, and could I work constructively with them?” The second is not permission for a panel to substitute personal liking for merit; it is a reminder that communication, insight, behaviour and teamwork are themselves relevant professional qualities.

The aim is not to manufacture a persona. Forced confidence can look brittle. Excessive modesty can hide your contribution. A relaxed, professional tone, direct answers, appropriate warmth and a willingness to think aloud when necessary help the panel see the colleague behind the CV.

The three kinds of confidence

Confidence in your competence: you provide evidence, quantify impact where possible and acknowledge the limits of your experience. Confidence in your judgement: you explain priorities, consider consequences, involve the right people and recognise uncertainty. Confidence in your character: you are fair, open, respectful and consistent. The most persuasive candidates demonstrate all three without announcing them.

INTERVIEW INSIGHT

> The panel is not only assessing what you have achieved. It is forming a view of how you are likely to behave when something goes wrong at 5 p.m. on a difficult Friday.

What the panel can and cannot know

A panel meets a candidate for a limited period and cannot directly observe every aspect of how that person works. Interviewers therefore construct an impression from examples, language, how the candidate responds to uncertainty and how they interact with the people in the room. This is why a clinically accurate answer may be insufficient: it may not show ownership, prioritisation, collaboration or awareness of unintended consequences. Conversely, an engaging performance cannot legitimately substitute for the required competence or evidence. A mature candidate recognises both dimensions and aims to make genuine strengths visible rather than manufacture a persona.

Consider two technically similar answers about a failed change project. The first says, “The team resisted, so management did not allow the project to progress.” The second says, “My initial proposal did not sufficiently address nursing workload; once I understood that, I redesigned the pilot with the team. We did not achieve the original timetable, but we developed a more sustainable model.” The second answer reveals accountability, insight, realism and consideration of others. These are not simply pleasant emotional signals; they are behaviours relevant to consultant performance.

Confidence, warmth and professional credibility

Candidates sometimes believe they must appear assertive at all times. In reality, a panel often has more confidence in someone who distinguishes the issues they understand from those requiring further information. A consultant must make decisions but must also know when to consult colleagues, revisit a conclusion or ask for specialist input. Authority comes from clarity about reasoning and accountability, not the volume of the voice or reluctance to admit uncertainty.

Warmth is the sense that colleagues and patients will be treated with respect. It is visible in the language used about others: whether you give credit, acknowledge a colleague's legitimate concern or describe a difficult patient as a human being rather than as an obstacle. Panel members may naturally imagine the successful applicant as their future colleague, but the assessment should still be grounded in fair, job-relevant evidence. Do not try to engineer a personal affinity with one panel member at the expense of the others.

2.2 Rapport, authority and authenticity

Professional authority is communicated through clarity, calmness and sensible decisions, not by speaking quickly or dominating the room. Answer the question directly; make your first sentence useful; explain your thinking; stop when the message is complete. Be willing to smile and engage with panel members, but do not overuse jokes or familiarity. Acknowledge different viewpoints without automatically agreeing with everything asked.

Use “I” when describing your personal contribution and “we” when giving colleagues appropriate credit. Candidates who use only “we” can make their impact invisible; candidates who use only “I” may appear to overlook the team. A mature answer shows both ownership and collaboration: “I proposed the redesign and brought the nurses, administrative team and fellow consultants together to test the pathway.”

Avoid diminishing language (“I only did a small audit”) and unsubstantiated superlatives (“I am an outstanding leader”). Instead, state the action, result and lesson. Modesty and confidence are compatible when you are specific and fair.

The “would I want to work with this person?” question

This is often discussed as the emotional component of consultant selection. It does not mean that candidates should try to be charming, tell jokes or flatter the organisation. The relevant issue is whether the answers convey a professional who is dependable, constructive, respectful and able to take responsibility. Thoughtful eye contact, direct answers and a calm response to probing questions can support this perception; defensiveness, blaming others or dismissing legitimate challenges can undermine it. Such impressions are subject to bias, so they should not become informal personal tests unrelated to the person specification.

A candidate can prepare by asking a trusted colleague to listen not just for factual content but also for the qualities the answer communicates. Does a story about an audit sound like collaboration or self-congratulation? Does a dispute story show curiosity or contempt? Does an account of a difficult outcome show ownership or excuses? The task is to improve the truthfulness and clarity of your account, not to perform artificially positive feelings.

2.3 Bias, perception and candidate responsibility

Panels are expected to follow fair processes, and interviewers should be aware of potential bias. Candidates cannot control the panel's perceptions, but they can make evidence easier to assess. Use examples with clear outcomes; explain local context without assuming everyone knows it; avoid unexplained acronyms; and distinguish objective facts from your interpretation.

Do not infer hidden meaning from a poker face, a difficult follow-up or a panel member writing notes. Interviewers may be following an agreed format. Similarly, do not assume the most senior member is the only person whose view matters. Keep the entire panel engaged and respect the role of every member.

A useful self-test is to ask: “If someone who has never met me read a neutral record of that answer, would they find enough evidence to rate me positively?” If not, the answer may depend too heavily on charisma or reputation.

Do not confuse information with an answer

A candidate can know a great deal and still fail to answer well. “Tell us what you know about the NHS 10 Year Health Plan” is different from “How would the 10 Year Health Plan affect your service?” The first invites a concise explanation of direction; the second demands translation into clinical reality, workforce, risks, priorities and action. Listen carefully for verbs such as describe, evaluate, prioritise, implement, demonstrate and reflect. They point to the kind of reasoning the panel wants to hear.

When a question is broad, a short opening position provides control: “I would approach this through three considerations: patient outcomes, staff capacity and practical implementation.” That is more helpful than announcing an elaborate acronym. Use a structure only if it helps the panel follow the answer. Bring the answer to a conclusion instead of adding unrelated policies to prove how widely you have read.

Answer, reasoning, evidence, relevance

Think of an answer as a chain. First answer the question directly. Next explain why the issue matters or what you would weigh up. Then provide an example or practical approach that demonstrates your judgement. Finally link the insight to the consultant role or employing service. If asked about difficulties, acknowledge the genuine trade-off rather than pretending every problem has a perfect solution. An answer that considers a sensible counterargument can sound much more mature than a confident but simplistic claim.

2.4 The anatomy of a strong answer

A strong answer usually has four qualities: relevance, structure, evidence and judgement. Start by answering the actual question, not a vaguely related one you have rehearsed. Signpost two to four ideas where helpful. Support claims with specific actions and results. Finish with the implication for the consultant role or advertised service.

There is no ideal duration for every answer. Simple questions require concise answers; complex scenarios justify more explanation. A practical discipline is to make your central point early, then add the evidence the question deserves. Listen for the distinction between “What makes you a good teacher?” (attributes and methods) and “How do you know you are a good teacher?” (feedback, impact, return invitations, outcomes). Those are different questions.

A flexible response pattern

Answer → Explain → Evidence → Relevance. For example, when asked about a strength: identify the strength, say how it affects your work, give a brief example and connect it to a specific responsibility in the post. Do not force this pattern into an urgent safety scenario or a detailed reflective account.

Before: “I have excellent leadership skills, and I have always been passionate about teamwork.” After: “One strength I would bring is the ability to help multidisciplinary groups agree practical changes. When our clinic's backlog grew, I brought together the nursing and booking teams, mapped the bottlenecks and helped pilot a revised triage process. We monitored waits and adjusted the pathway in response to staff feedback. That combination of engagement and measurement would be useful in this department's access work.” The second example is illustrative: use only results that are genuinely yours.

2.5 Questions that require no acronym

Not every question is best answered through a mnemonic. “What is the biggest challenge facing this service?” may call for a concise analysis of demand, capacity, quality and resources. “How would you improve our clinic?” is better handled through diagnose → prioritise → engage → implement → evaluate. “What are your weaknesses?” requires self-awareness, a genuine example and evidence of improvement. “Why here?” calls for a convincing match between the service's needs and what you want to contribute.

The real skill is selecting a structure that follows the task. If the panel asks for one example, give one. If it asks how you would act, do not spend the whole answer describing what you did in another hospital. If it asks for your view, state a balanced position rather than giving a policy lecture.

Handling probing questions

A follow-up is not necessarily criticism. It may be an invitation to demonstrate depth. Listen to the whole question, acknowledge the specific concern and respond with reasoning. It is acceptable to say, “That would depend on the level of risk and what we know at that point,” then explain what would change your decision. Avoid defending an earlier answer simply because you have already said it.

2.6 Delivery: presence, listening and online interviews

Make eye contact across the panel; in a video interview, address the camera regularly without staring at it. Sit or stand comfortably, speak at a sustainable pace and leave short pauses between ideas. Do not fill silence with unnecessary qualification. If you lose your thread, pause, restate the question in your own words and continue. That is more credible than apologising repeatedly.

For online interviews, test the platform, camera, microphone and connection, prepare a neutral background and place your notes where they do not tempt you to read. Ask in advance about presentation sharing and contingencies for technical failure. For in-person interviews, allow time for travel and check the venue, format and practical arrangements.

Avoid rehearsing gestures or facial expressions. Instead, practise difficult material enough that you can remain engaged with the people listening. Your goal is professional conversation with structure, not a performance of someone else's personality. Sections 2.9-2.13 develop answer length, the three-points approach, body language, dress code and speaking with impact in more detail.

2.7 Managing nerves and the unexpected

Nerves are compatible with an excellent interview. Your objective is not to remove every sign of anxiety but to remain able to listen, think and speak. Prepare the opening of your first answer, because the first minute often feels hardest. Rehearse recovery from an interruption, a difficult challenge and a question you do not understand. Use a short pause before answering rather than filling the silence immediately.

If you lack information, say so and explain how you would find out. If the panel challenges an assumption, adapt calmly. If you give an imperfect answer, continue rather than trying to repair it repeatedly throughout the rest of the interview. Interviewers may remember your ability to recover more than a small hesitation.

Useful recovery phrases: “There are two issues I would separate here…”; “The first priority would be patient safety…”; “I would want to understand the local data before recommending a specific change…”; “I can give an example of how I have approached a similar problem.” Use these as conversational tools, not prewritten answers.

2.8 Build an answer the panel can follow

A useful first sentence performs a job. It answers the question, states your position or identifies the central judgement. "There are three priorities I would address" can work, but only if the priorities genuinely answer what was asked. An opening such as "Leadership is very important in the NHS" usually consumes time without moving the answer forward.

Think of your answer as a sequence of decisions about relevance. What does the listener need in order to understand the problem? Which action reveals something distinctive about your judgement? What evidence supports the result? What can be omitted without changing the meaning? Preparation should make these choices easier, not produce a speech so polished that you cannot adapt it.

Match the depth to the question

"What is your greatest strength?" requires a clear quality supported by selective evidence. "Tell us about a time you used that strength" invites a fuller example. "What would you do differently?" requires reflection, not a second recital of the whole project. Listen for that change of task. Candidates often appear evasive because they answer the question they expected rather than the narrower question that was asked.

With a multipart question, briefly identify its elements before answering. For example: "I would separate the immediate staffing risk from the longer-term causes of dissatisfaction." Deal with both and return to any part left open. A short pause to organise your thoughts is usually more useful than beginning immediately and discovering halfway through that you have lost the second part.

Distinguish confidence from certainty

Confidence means that the panel can follow your reasoning and understand the limits of your knowledge. You can be decisive about immediate safety while remaining open-minded about why the problem arose. You can support a national direction while recognising local implementation difficulties. You can take responsibility without pretending that one individual controls the whole system.

A constructive response to challenge has three parts: acknowledge the information or concern; explain whether it changes your view; state the next practical step. "That staffing constraint would change the scale of the pilot. I would not proceed on the assumption that the current team can absorb the work" demonstrates flexibility without abandoning the original aim.

IN PRACTICE

The panel challenges your proposal

A candidate proposes a new specialist clinic. A panel member explains that there is no additional nursing capacity. One response is to repeat that the clinic would be beneficial and that staff must be flexible. A better response revisits the design: could demand be addressed by advice, joint review or a smaller pilot within existing capacity? What would need to stop or change?

The stronger candidate does not treat the challenge as an attack. They demonstrate that a service idea is a hypothesis to test with colleagues, not a personal campaign to defend at any cost.

Finish without undermining the answer

Once the question has been answered, stop. Repeated qualifications can obscure a sensible conclusion. "Of course, there are many other things, and it depends, and I would have to see" can turn a proportionate answer into an uncertain one. Specify the uncertainty that matters: "I would confirm the baseline and staffing position before agreeing the scale of implementation."

Your closing sentence can identify the skill or principle demonstrated. It should not simply announce that you are an excellent communicator. Explain the evidence: "The lesson was that understanding why colleagues objected let us redesign the process and retain their involvement." That conclusion makes the professional value of the example visible.

Give yourself a fair preparation environment

Do not try to erase an accent, disguise a disability or imitate someone else's personality. Practise intelligibility, relevance and pacing. Where you need recruitment adjustments, discuss arrangements with the employer in advance rather than trying to compensate privately on the day. The aim is a fair opportunity to demonstrate the requirements of the role, not a performance of an imagined ideal personality.

2.9 How long should an answer be?

An interview answer needs enough substance to demonstrate your judgement, but not so much detail that the panel has to search for your point. A useful rehearsal target for many initial answers is around 90 seconds to two minutes. This is a coaching guideline, not an official consultant recruitment rule. The wording of the question, any stated time limit and the interviewer's follow-up should take priority.

A short factual question may need only a sentence or two. A focused follow-up might take 20 to 45 seconds. A broad introduction, substantial project or service vision may reasonably need two to three minutes when the panel invites that depth. A presentation has its own specified timing. Do not turn every response into a two-minute speech or assume that a long interview gives you unlimited time for each question.

Aim for sufficient evidence, not maximum airtime

An answer is too short when it contains only assertions: "I am approachable, organised and a good team player." It is too long when further detail no longer helps the panel judge the relevant capability. Names of meetings, the order of emails, an exhaustive clinical history and every obstacle encountered often add time without adding evidence.

For a leadership example, the panel needs to understand the problem, your contribution, how you worked with people, the outcome and your reflection. It does not usually need a diary of the project. Give a concise overview and outcome, then explain two or three meaningful challenges or aspects, as described in Chapter 5. Preserve the reasoning and the result; remove incidental chronology.

A practical two-minute rehearsal

As an exercise, allow approximately 15 seconds to answer directly and establish context, about 90 seconds to develop the main evidence, and 15 seconds for the result, learning or relevance to this post. These proportions are deliberately approximate. A weakness answer, for example, needs enough time for the management of the weakness; a safety scenario needs the urgent action first, not a lengthy introduction.

Record yourself once, listen without looking at your notes, and ask which sentences change the listener's understanding. Cut repeated claims before cutting the evidence. Speak at a comfortable conversational pace. Trying to fit a four-minute script into two minutes by speaking faster makes the answer harder to follow.

Recognise when to stop

End when you have answered the question, demonstrated the relevant skill and made the implication clear. A short concluding sentence is useful; a second conclusion and several further qualifications are not. You do not need to ask "Have I answered your question?" after every response. Leave room for the panel to explore the part that interests them.

If interrupted, stop and listen. A follow-up may indicate interest, a request for clarification or time management; it is not automatically criticism. Answer the new question rather than insisting on completing your prepared material. If your response genuinely requires several stages, signpost them briefly and adjust when the interviewer directs you.

PRACTICE EXERCISE

One example, three lengths

Prepare the same genuine leadership example in 60-second, two-minute and three-minute versions. Keep the problem, your contribution and the outcome in all three. Use the longer versions for additional reasoning and evidence, not more background. This teaches you to adapt without losing the substance.

2.10 The three-points rule: organise, explain and illustrate

Three main points are often a useful starting point for an answer because they encourage selection and give the listener a clear route through your reasoning. They are not a scoring formula. Use two strong points rather than inventing a weak third; use four when the question or framework genuinely requires four. CAMP has four areas and SPIES has five elements. Neither should be distorted simply to obey a rule of three.

Think in themes rather than isolated words. "Communication, teamwork and leadership" may overlap so much that each part repeats the last. More distinct themes might be "making the pathway reliable", "securing the team's support" and "making the change sustainable". Each should demonstrate a different aspect of your contribution.

Give each point enough substance

For each theme, state the point, explain your reasoning, provide a short example or practical action and show why it matters. Three unsupported claims are still unsupported claims. Equally, giving a complete five-minute STAR story under each heading defeats the purpose of a concise structure. Use a brief evidence fragment and retain the fuller account for follow-up.

For "How would you improve our service?", a sensible initial structure might be understanding the current problem, agreeing and testing a feasible improvement, and measuring and sustaining the benefit. Explain what information you would seek, whose involvement is necessary and how you would avoid improving one part of the pathway at another team's expense. The headings are only the beginning of the answer.

Signpost without sounding mechanical

A brief opening such as "I would focus on three areas" can help. Make the areas meaningful: "the immediate risk, the reasons the problem is recurring, and the support and follow-up needed". Then move directly into the first point. There is no benefit in announcing a long contents list and repeating it word for word before the answer starts.

Within a prepared example, thematic organisation is often stronger than "first this happened, then that happened". When recalling an unexpected example, chronology may be easier. Keep it selective, then explicitly identify the result, what you learnt and the skills the example demonstrates. Structure should reveal your thinking, not conceal a failure to answer the question.

WORKED APPROACH

Three themes for a consultant leadership answer

Change: explain how you found a better way of organising the work. People: describe how you listened, secured cooperation and developed colleagues' ownership. Result: explain what improved, how you know and whether the improvement lasted. This uses CPR to select evidence, not to recite an acronym to the panel.

2.11 Body language: professional, approachable and engaged

Body language should support what you are saying, not become a second performance to manage. The aim is to appear professional, approachable and engaged rather than to memorise gestures. At consultant level, think about the colleague you would want to work with: someone who listens, explains decisions clearly and remains constructive when challenged.

Prepare the substance of your answers first. Familiarity with your examples usually makes it easier to engage naturally with the panel. There is no need to adopt an exaggerated 'leadership posture', maintain a fixed smile or copy somebody else's mannerisms. No single gesture establishes competence, confidence or honesty.

Eye contact: include the panel, rather than performing a circuit

Begin your answer by engaging with the person who asked the question. As you explain your points, include the other panel members naturally. You are addressing a mixed panel, not having a private conversation with the clinical specialist whose interests are closest to your own. Do not mechanically turn to a different person at the end of every sentence.

It is natural to look away briefly while thinking. The objective is contact and engagement, not staring. Avoid reading a prepared answer from your notes or repeatedly looking down when you could be explaining the point to the panel. Equally, a panel member looking down may simply be recording evidence: do not keep adding detail until they look up.

Posture: comfortable and attentive, not rigid

Choose a position in which you can breathe and speak comfortably. Where comfortable for you, sit with your back supported, shoulders relaxed and feet resting securely. Avoid perching on the edge of an unstable chair or forcing yourself to remain unnaturally still. A slight movement towards the questioner may feel natural, but leaning forward continuously is not a requirement.

Try the practical arrangements during rehearsal. Can you see the panel, use your notes briefly and speak without twisting towards a screen? Adjust the chair or ask for an appropriate arrangement before the interview starts where possible. Physical discomfort is a distraction that good preparation can sometimes remove.

Hands and gestures: reinforce the explanation

If you normally gesture when speaking, there is no need to suppress every movement. A small gesture can help distinguish alternatives or mark a transition between themes. If you do not naturally gesture, do not introduce rehearsed movements simply because you have been told they look confident.

Remove avoidable distractions such as a clicking pen, jangling accessories or a phone on the table. Rest your hands comfortably when you are not using them. The point is not to police every movement: involuntary movements or disability-related behaviours are not professional failings, and a candidate should not be judged against a single idealised physical style.

Facial expression: match the subject

A natural greeting and an interested expression can help establish a professional conversation. Warmth is appropriate when discussing an achievement or why the post appeals to you. A discussion of a clinical mistake, harm or discrimination calls for an expression and tone that recognise its seriousness. You do not need to smile throughout the interview.

Notice how you respond when challenged. An immediate laugh, sigh, raised eyebrow or visible frustration can distract from an otherwise sensible answer. Pause, listen and address the point. You do not have to agree with the interviewer, but your response should demonstrate that you can consider another perspective without becoming dismissive.

Your listening matters as much as your speaking

Allow the questioner to finish. Listen for whether the follow-up asks for evidence, reflection or a different aspect of the example, rather than preparing to repeat your original answer. A brief acknowledgement is enough; repeated nodding or enthusiastic agreement with every statement can feel artificial.

If interrupted, stop and listen. The panel may be managing time or pursuing an interesting detail. A calm 'Of course' followed by a direct answer is more useful than trying to complete a prepared speech. Where a question is unclear, ask a focused clarification rather than guessing. These moments show how you take part in a professional discussion.

IN PRACTICE

When a panel member challenges your proposal

A candidate proposes a new clinic. The clinical director says that the nursing team has no spare capacity. Rather than frowning and repeating the benefits, the candidate pauses and replies: 'That changes what would be feasible. I would first establish whether we could redesign the existing pathway; I would not assume the team could absorb an additional clinic.' The response combines attentive listening, calm delivery and a willingness to adapt. It is the professional behaviour, not a particular pose, that matters.

Online interviews: make the conversation easy to follow

Position the camera close to eye level, with your face clearly lit and enough of your upper body visible for natural movement. Look towards the camera periodically when speaking and at the screen when listening. Staring at the lens throughout can make it harder to follow the people asking questions. Test the actual microphone, connection and setting you will use.

Keep any permitted prompts brief and close to the screen. Do not place a full script beside the camera. Allow a small pause before responding if there is a connection delay, and ask for repetition when sound breaks up. Disable notifications and have the recruitment team's contact details available in case of a technical problem.

Authenticity, access and rehearsal

Eye contact, movement and expression vary with disability, neurodivergence, culture and individual communication style. Effective communication does not require masking a disability or adopting a different identity. Use any agreed recruitment adjustments and practise in a way that works for you. Concentrate on being understandable, responsive and engaged.

PRACTICE EXERCISE

Review one answer, not every gesture

Record a two-minute answer and review it in two passes. First listen without watching: is the message clear, well paced and supported by evidence? Then watch: do you appear attentive, and is there one avoidable distraction worth changing? Ask a trusted colleague for specific observations. Change one thing at a time rather than trying to choreograph your entire performance. Section 2.13 develops the language and delivery of an impactful answer.

2.12 Dress code: professional, comfortable and appropriate

Choose smart professional clothing that you can sit, stand and speak in comfortably. A suit, jacket with tailored separates, smart dress or another equivalent professional outfit can all work. There is no need to buy expensive clothes, adopt a gendered uniform or change your cultural or religious dress to look like someone else's idea of a consultant.

The interview invitation takes priority if it specifies dress or practical requirements. A conventional panel interview is different from a ward visit or patient-facing assessment. Do not assume that a clinical dress policy applies to every interview setting; equally, follow local safety and infection-prevention requirements when entering clinical areas.

Remove avoidable distractions

Check fit, cleanliness and comfort beforehand, including how the outfit feels when seated and when delivering a presentation. Choose shoes you can travel and walk in safely. Consider whether accessories create noise, interfere with a microphone or repeatedly need adjusting. Avoid strong fragrance. These are practical considerations, not judgements about personal style or identity.

A tie, make-up, heels, particular hairstyle or costly accessory is not evidence of consultant competence. Select an appearance that feels professional and authentic to you. The panel should be able to concentrate on your contribution rather than on your discomfort. Clothing required for disability, health, culture or faith should not be treated as a distraction to remove.

Prepare for the real setting

For an online interview, test the outfit on camera: busy patterns, reflections and very low contrast against the background can be distracting on some screens. Dress appropriately for the whole interview, including the

possibility of standing up. For an in-person interview, allow time to remove outdoor clothing, check your appearance and settle before you are called in.

FINAL CHECK

Make presentation one less thing to worry about

The day before, confirm the format, clothing, travel or connection arrangements, documents and presentation instructions. On the day, focus on listening and explaining. Professional appearance supports your message; it cannot replace evidence, judgement or preparation.

2.13 Speaking with impact: power words, ownership and delivery

Speaking with impact means making your contribution easy to understand and remember. It does not mean using grand language, speaking loudly or making every project sound transformational. Taking ownership of your achievements means explaining what you actually did, how you influenced the work and what happened as a result. The same principle applies at consultant level, with greater emphasis on judgement, colleagues and service delivery.

A panel cannot infer your role from a job title or the name of a project. 'I was involved in a pathway redesign' gives little indication of whether you identified the problem, secured agreement, implemented the change or simply attended meetings. A precise account lets the panel recognise the skills you have, without requiring you to advertise yourself through unsupported adjectives.

Start with the contribution, not an account of your good fortune

Phrases such as 'I was lucky enough to', 'I had the opportunity to' and 'I was asked to help' can make the experience sound as though it merely happened to you. You can acknowledge an opportunity or a colleague's support while still describing how you used it. 'Working with the service lead, I analysed the delays and coordinated the pilot' is more informative than 'My consultant let me get involved'.

Avoid unnecessary self-minimising language such as 'I just helped with' or 'It was only a small project'. A limited piece of work may still demonstrate excellent judgement or influence. State its scope accurately and explain its value. Equally, do not change 'contributed to' into 'led' unless you genuinely led the work. Clear language should reveal the contribution, not enlarge it.

Use precise action verbs: the useful meaning of power words

Action verbs describe something you did. They are more useful than general claims such as 'dynamic', 'excellent' or 'highly effective'. 'Analysed', 'negotiated', 'coordinated', 'implemented' and 'evaluated' each tell the panel something different. Select the verb that matches the evidence, then explain what you acted on and why it mattered.

This is not a vocabulary test. A familiar, accurate verb is better than an impressive word you would never normally use. 'Led' is not automatically stronger than 'supported': supporting a colleague through a difficult change may be exactly the leadership evidence the question requires. Prepare a personal vocabulary rather than trying to insert a power word into every sentence.

Choose verbs that describe the work

Area of contribution	Useful action verbs
Change and lateral thinking	Questioned, analysed, identified, devised, redesigned, piloted
People and relationships	Listened, engaged, facilitated, negotiated, coached, mentored
Result and delivery	Prioritised, coordinated, implemented, delivered, measured, sustained
Quality and research	Audited, appraised, investigated, evaluated, compared, recommended
Teaching and development	Designed, taught, adapted, supervised, debriefed, developed
Professional judgement	Clarified, balanced, escalated, documented, reflected, adapted

The first three rows connect directly to CPR: Change, People and Result. They help you demonstrate that you can think differently, work through and support colleagues, and get useful work completed. They do not require a leadership title or imply that every achievement belongs to you alone.

Replace vague descriptions with specific actions

The following pairs illustrate the difference. They are examples of wording, not claims to borrow: use an alternative only when it accurately describes your own work.

From participation to a clear contribution

Vague description	More specific description
I was involved in improving the referral pathway.	I mapped the referral process, identified where incomplete information caused delays and coordinated a pilot with the clinical and administrative teams.
I attended the service-development meetings.	I presented the demand data, clarified the staffing implications and helped the group agree a realistic scope for the pilot.
I helped a colleague who was struggling.	I met the colleague privately, explored the pressures and agreed a supported plan with clear priorities and follow-up.
We introduced a new teaching programme.	I designed the learning objectives and coordinated the faculty; colleagues delivered the sessions, and we reviewed feedback together.
I improved efficiency.	I reviewed where work was being repeated, agreed a clearer allocation of tasks and checked whether the revised process reduced duplication.

Use I and we for different purposes

Use 'I' to identify your decisions, actions and responsibility; use 'we' to acknowledge collaboration and shared results. An answer that uses only 'we' can hide your contribution. An answer that uses only 'I' can erase the colleagues on whom the work depended. Neither is a reliable picture of consultant leadership.

A balanced account might be: 'We redesigned the follow-up pathway. I coordinated the pilot and negotiated how the additional administrative work would be covered. The nursing team developed the patient information, and we reviewed the feedback together.' This shows ownership while recognising the expertise and effort of others.

Be equally precise when the result was limited. 'I led the initial analysis, but the pilot was delayed because we had not secured administrative capacity' is more credible than claiming a completed transformation. Explain the action you took, the result achieved so far and what you would change. Accurate limits strengthen rather than weaken the account.

Connect action to judgement and outcome

A string of verbs is still only a list. 'I organised, coordinated and implemented' does not explain whether your choices were sensible. Connect each important action to the problem it addressed and the difference it made: 'I negotiated a smaller initial pilot because the proposed model exceeded the team's capacity.' The reason reveals judgement; the subsequent evaluation shows whether the decision helped.

Use numbers where they are accurate, relevant and understandable, but do not manufacture precision. Distinguish a measured reduction from an impression, an association from proof of causation, and an early improvement from a sustained result. Qualitative evidence such as clearer responsibility or useful staff feedback can be valuable when described honestly. Explain the source and limitations rather than attaching a confident percentage to every claim.

WORKED EXAMPLE

The same contribution, explained more clearly

Less effective: 'I was fortunate to be involved in a project to improve follow-up. I attended the meetings and helped introduce the new process.'

More informative: 'I mapped the follow-up pathway and identified that unclear responsibility was causing repeated queries. Working with the nursing and administrative leads, I agreed a named owner for each stage and coordinated a small pilot. Staff feedback suggested fewer duplicated queries, although we had not yet completed a longer-term review. My contribution was turning a broad concern into a workable process and bringing the relevant teams together.'

The second version identifies actions, collaboration, a proportionate result and its limitation. It is an illustrative example, not a model achievement to reproduce.

Make the first sentence and the transitions work

Answer the question before explaining the background. Asked about a strength, begin with the strength and its relevance, not a general statement that leadership is important. Asked about a difficulty, identify the difficulty and the judgement it required. A useful opening gives the panel a reason to listen to the evidence that follows.

Organise the answer into a few meaningful themes and use brief transitions: 'The main challenge was gaining agreement'; 'A second issue was making the process sustainable'; 'The result was'; 'What I would do differently is'. You can signpost before an example or draw out its meaning afterwards. In either case, the listener should understand why you included it.

Prefer concrete language to abstract phrases. Instead of 'I facilitated stakeholder engagement', explain that you met the nursing and administrative leads to understand their concerns. Use necessary professional terms, but translate specialist detail for the non-clinical panel members. Plain language can carry complex reasoning without sounding simplistic.

Use your voice to emphasise meaning

Speak at a comfortable conversational pace. Pause briefly between themes and after an important result or reflection, rather than accelerating to fit in more material. Shorter sentences often make complex decisions easier to follow. Use natural variation in tone to distinguish what interested you, what concerned you and what you learnt; avoid delivering every sentence with identical emphasis.

You do not need to remove every hesitation. A thoughtful pause is preferable to repeated fillers or an immediate answer with no direction. Repeated qualifiers such as 'just', 'sort of' or 'I suppose' can obscure a clear claim, but legitimate uncertainty should remain. 'The early feedback was encouraging; the outcome data were not yet available' is appropriately precise, not weak.

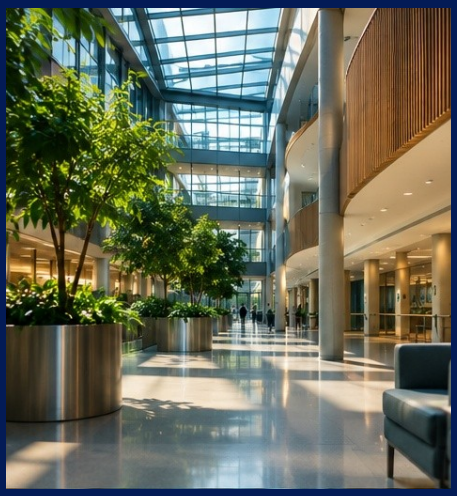
Finish when your point is complete. A concise closing sentence can identify the learning or contribution: 'That experience taught me to agree capacity and ownership before launching a change.' Avoid a second summary, an apology for the example or a claim that the experience proves you are an outstanding leader. Let the evidence carry that judgement.

PRACTICE EXERCISE

Build your own consultant interview vocabulary

Choose around 30 action verbs that feel natural to you, drawing from different areas of work. For each, identify a genuine action you could explain and defend. Then rewrite the opening of five answers: remove vague participation language, specify your contribution, acknowledge colleagues and include the outcome or learning. Rehearse aloud rather than memorising the wording. Keep the version that sounds like you and makes the work easiest to understand.

03
Research and pre-interview visits



Investigate the job, ask useful questions and turn local understanding into a credible contribution.

01 Research the role | 02 Plan useful conversations | 03 Apply local insight

3.1 Trust and department research: what to look for

Research should be selective and purposeful. Start with the employer's strategy, annual report, quality and performance reports, CQC findings where applicable, workforce priorities, and relevant system or ICB documents. Read the specialty's public information and any clinical network or university partnership information. Prepare questions about how the job functions in practice, not questions whose answers are obvious from the advertisement.

One-page service briefing — complete before the interview

Prompt	Your notes
Role and distinctive responsibilities	_____
Population served; key partners	_____
Two credible service strengths	_____
Two challenges or unanswered questions	_____
Current access/quality/workforce measures	_____
Most relevant NHS strategic shift	_____
Stakeholders to meet and questions to ask	_____
Where your experience offers value	_____

A pre-interview visit is an opportunity for mutual understanding. Arrange it appropriately through the recruitment contact and use it to listen. Meet the prospective colleagues and relevant leaders where offered; ask about priorities, relationships, patient pathways, job planning and expected contribution. Avoid canvassing for support or seeking privileged information, and be respectful of the time staff give you.

3.2 Pre-interview visits: preparation, conversations and judgement

The pre-interview visit is not a covert additional interview, nor is it a touristic exercise in collecting names. It is an opportunity to understand the service, assess whether the appointment is right for you, and form a credible view of how you might contribute. People you meet may remember your professionalism and curiosity. Treat every conversation respectfully, including those with coordinators, nurses and administrative colleagues.

Who to meet and how to arrange it

Follow the recruitment instructions and arrange meetings through appropriate channels. Depending on the post, useful conversations may include the clinical director or head of service, consultant colleagues, medical director, operational management, nursing or AHP leads, education and research leads, and service users where formally arranged. You cannot expect access to everyone. Prioritise people who can illuminate the clinical role, strategic direction, team culture, service pressures and expectations of a new consultant.

Research before you visit

Read the person specification, job plan, relevant trust strategy, published outcomes, inspection information where relevant, and recent service developments. Note what you know, what is uncertain and what you want to validate. Prepare two or three thoughtful questions per meeting, tailoring them to the person's perspective. Do not ask busy leaders for facts easily found in the job description.

Questions for the clinical director and consultant colleagues

What are the service's most important priorities over the next two years? Where is the greatest variation in quality or access? What do you hope the new consultant will contribute that the current team cannot easily provide? How are clinical decisions and disagreements resolved? What would successful performance in this role look like after 12 months? How do colleagues support each other during periods of pressure? Ask with curiosity, not as a checklist read aloud.

Questions for operational, nursing and AHP leaders

Which patient journeys generate the greatest friction? What are the recurring workforce and flow challenges? Where do handovers or interfaces between teams fail? Which recent changes have succeeded and why? How are staff concerns heard? What would make the greatest difference to patient and staff experience? These perspectives are often more useful than another discussion of tertiary clinical expertise.

What to listen for beneath the answers

Look for patterns across conversations, not isolated remarks. Do people share an understanding of priorities? Is there a credible approach to patient safety, learning and quality improvement? Are colleagues open about constraints? Is there a constructive culture of challenge? Do expectations match the advertised job plan? Keep an open mind: one person's account may be incomplete, and sensitive information should not be solicited or repeated.

How to present yourself

Have a concise explanation of your background and why the post interests you. Be interested rather than performative. Give examples when helpful, but avoid turning each meeting into a sales pitch. Respect time limits, do not make promises about changes you cannot deliver, and do not criticise the department to demonstrate expertise. If you disagree with what you hear, ask a clarifying question before forming a judgement.

IN PRACTICE

Listen before proposing a solution

A candidate hears that clinic delays are a major problem. A poor reaction is to announce a new digital triage system. A better reaction is to ask where delays occur, which patients are most affected, what has already been tried and how nursing and administrative colleagues see the pathway.

At interview the candidate can then propose a measured, co-designed exploration rather than a premature solution.

What to avoid

Do not seek inside information about other applicants, ask panel members to reveal likely questions, attempt to influence the selection process, or treat informal impressions as promises of appointment. Do not gossip or repeat confidential comments to other visitors. Do not presume that a friendly conversation establishes an advantage. Keep boundaries professional and respect local recruitment fairness.

Immediately after the visit

Record facts separately from impressions. Summarise three service priorities, two areas needing clarification, one opportunity where you may add value and one concern you should explore further. Translate this into your motivation answer, your presentation and your first-year priorities. Send a brief courteous thank-you where appropriate, without campaigning for the appointment.

Turning the visit into a stronger interview answer

Try: “From the published strategy and my conversations with the team, I understand that improving access while maintaining clinical quality is a central priority. I was particularly interested in the interface between referrals and diagnostics. I would first want to validate the pathway data with clinical and operational colleagues, then explore changes that are safe, feasible and measurable.” This shows listening and preparation without claiming to know the service better than its staff.

PRE-VISIT WORKSHEET

Your pre-visit preparation

Write down: three things I already know; three things I need to understand; the people most relevant to those questions; one sentence describing my distinctive contribution; and three potential questions the panel may ask because of the service’s priorities.

3.3 Plan a visit that answers real questions

A successful visit is not measured by how many senior people you meet. It is measured by how much better you understand the job afterwards. Start with the uncertainties that affect your decision to apply and the contribution you could make. These might include how the post fits within the team, how cross-site work operates, which service pressures are most important or what support a new consultant receives.

Make a one-page plan before arranging conversations. Record what you already know from public documents, what you need to clarify and who is likely to have a useful perspective. This prevents you from using a clinical director's limited time to ask questions answered on the first page of the job description.

Arrange the conversation professionally

Use the named contact or the recruitment team. State the post, your interest and the topics you would value discussing. Offer flexibility and keep the request proportionate. A focused telephone or video conversation can be useful where an in-person visit is impractical. Do not interpret an unavailable diary as evidence that the department is uninterested in your application.

A suitable message might say: "I am applying for the consultant post in your department and would value a conversation about the priorities for the role and how the new appointee would contribute to the service. I have read the job description and would particularly like to understand the cross-site responsibilities and the planned pathway developments. I am happy to fit around the team's availability."

Ask questions at the right level

With a clinical director, explore priorities, team configuration, quality risks and the contribution expected over the first year. With a service manager, explore demand, capacity, staffing dependencies and practical delivery. With nursing and allied health colleagues, ask where communication works well, where patients encounter difficulties and how consultant input can help. With potential peers, explore collaboration, on-call arrangements, mutual support and how decisions are made.

The same question can be useful across groups: "What would you most like the new consultant to help the department achieve?" Different answers are information, not necessarily evidence of dysfunction. They may reveal different responsibilities or competing priorities that the successful appointee will need to understand.

Look beyond the appealing parts of the job

A role can be clinically attractive but difficult to deliver as described. Ask how the clinical commitments, supervision, governance, teaching and service development fit together. Clarify whether proposed developments are agreed, funded and staffed, or are longer-term ambitions. Understand travel, cross-site responsibilities, administrative support, equipment and how the job plan will be reviewed. These are questions about safe, sustainable practice rather than a lack of enthusiasm.

Be particularly careful with a newly created role. Who owns its objectives? What happens if the expected support is delayed? Which existing responsibilities will it share? An interview answer that recognises dependencies is more credible than an ambitious promise based on resources that may not exist.

Listen without joining factions

You may hear frustration about another specialty, management or a particular colleague. Do not reward disclosure by agreeing with criticism. Acknowledge the practical difficulty and ask about the process: "How are these disagreements currently resolved?" or "What would make that interface work better?" You are trying to understand a system, not recruit allies.

Do not quote a named colleague's criticism at interview. Translate what you have learnt into a neutral question or an appropriately cautious observation. "I understand that improving the interface with community services is a priority" is different from "The ward sister told me that discharge planning is poor."

IN PRACTICE

Three conversations, three priorities

The clinical director describes a waiting-list problem. The manager emphasises clinic capacity. The nursing team describes frequent late changes that disrupt preparation. The candidate initially considers proposing more clinics, then recognises that reliability may be part of the capacity problem.

At interview, the candidate explains that they would first map cancellations and late changes with the team before assuming that additional activity is the only solution. The visit has produced a better question and a more realistic contribution, not inside information or a claim to know the department better than its staff.

Turn observations into an interview answer

After each conversation, separate facts, reported perspectives and your own hypotheses. Record what surprised you, what remains uncertain and which of your experiences may be relevant. A sensible transfer into the interview has three components: what you understand about the service; the relevant experience you bring; and the way you would validate and adapt your contribution with the team.

For example: "The emphasis on improving referral quality particularly interests me. In my current service I helped redesign the information required at referral. I would not assume the same solution belongs here, but I could contribute the approach of mapping rework, involving referrers and testing a simpler process."

Recognise the boundaries of a visit

A visit is not consent to inspect identifiable patient information, enter clinical areas unescorted or discuss confidential staff matters. Follow local arrangements. Do not seek interview questions, commitments of support or reassurance that you are the preferred candidate. Formal assessment events should be identified as such; preliminary visits should not be presented as a covert selection round.

Send a brief thank-you that acknowledges the time and useful discussion. Do not send an unsolicited business plan or a long stream of further questions. Preserve the distinction between being interested, being prepared and trying to secure an advantage through personal pressure.

3.4 A focused question bank for pre-interview conversations

Conversation	Useful question	What it helps you understand
Clinical leadership	What would a successful first year in this post look like?	Priorities and realistic expectations.
Consultant colleagues	How are difficult service decisions discussed and agreed?	Working relationships and decision-making.
Nursing / AHP leadership	Where would consistent consultant involvement make the greatest difference?	Team needs and practical interfaces.
Operational management	Which bottlenecks are within the department's control and which depend on other services?	The difference between local action and system constraints.
Education leads	How are supervision, feedback and protected learning supported?	Whether educational responsibilities are deliverable.
Research / academic leads	Which collaborations and infrastructure would support this role?	The difference between academic ambition and available support.

PUT IT INTO PRACTICE

Prepare a useful visit

Choose five unanswered questions about the job. Assign each to the most appropriate conversation and separate public facts from issues that genuinely need discussion.

Self-check: Can you explain what you learnt without repeating private criticism or claiming certainty you do not have?

04
Presenting your professional contribution



Use CAMP for your professional story, CPR for your strengths and specific evidence of how you manage your development needs.

01 Use CAMP selectively
02 Strengths and self-management
03 Motivation and contribution

C	A	M	P
Clinical	**Academic**	**Management**	**Personal**
Your scope, judgement and contribution.	Teaching, research and evidence.	Leadership and service delivery.	Relevant qualities with evidence.

4.1 CAMP: structuring your professional contribution

CAMP stands for Clinical, Academic, Management, Personal. It is particularly useful for broad questions about your background, readiness, strengths, future aspirations or contribution. It gives you four lenses through which to select examples without simply narrating your CV chronologically.

Lens	Useful evidence
C — Clinical	Breadth, specialist experience, relevant pathways, outcomes, service needs
A — Academic	Teaching, supervision, scholarship, research, critical appraisal and evaluation
M — Management	Leadership, governance, audit, change, capacity planning, multidisciplinary work
P — Personal	Values, motivation, self-awareness, resilience and what makes you a constructive colleague

For “Tell us about yourself”, a good CAMP response does not need four equally long paragraphs. Clinical experience and management contribution may matter most for a particular post; academic contribution may focus on teaching rather than research; personal qualities should be evidenced rather than turned into a list of adjectives. You may change the order or omit a lens when it is irrelevant.

PREPARATION PROMPT

Under each letter, write a maximum of three claims that are true, relevant and supported by evidence. Circle the three that most clearly differentiate you for this particular consultant role. Those are the foundations of your introduction.

CAMP is an editorial tool for the candidate's professional story

CAMP works particularly well when the panel asks an open question and you must decide what to include. Its four headings are Clinical, Academic, Management and Personal. In each domain, write two or three pieces of evidence and then choose the information relevant to the advertised job. A consultant leading a complex clinical pathway may emphasise depth of subspecialty experience, supervision, pathway improvement and dependable teamwork. An academic appointment may justify greater weight on teaching and research. No category automatically deserves a quarter of the speaking time.

Clinical is not a catalogue of procedures. Explain the clinical scope you can contribute, the services or populations you have worked with and the particular need you meet. Academic does not require everyone to have major research grants: teaching, supervision, appraisal of evidence, guideline work, quality improvement and research may be relevant, depending on the post. Management means how you improve systems and use resources, not merely whether you have held a title. Personal means the attitudes and qualities colleagues can expect to see in your behaviour, supported by examples rather than self-description.

A poor introduction, and why it fails

A weak “Tell us about yourself” answer often walks through jobs in chronological order, lists every qualification and ends by saying “I am hardworking and passionate.” This makes the panel do the work of extracting relevance. A stronger introduction begins with an organising message such as the particular contribution you can make to this service, selects a few pieces of evidence from CAMP and finishes with why the post is a sensible next step. Be economical about early career chronology and do not force any category that has little relevance to the question.

Exercise: two versions of the same introduction

Prepare a 60-second introduction and a fuller 120-second version. Both should communicate the same professional identity and distinctive contribution. The second adds evidence; it should not drift into more background history. Read the person specification afterward and underline exactly which requirements your introduction has demonstrated. If the evidence is not visible, revise the selection rather than adding adjectives.

4.2 Tell us about yourself: tell a coherent story

“Tell us about yourself” is rarely an invitation to recite every training post. It is your opportunity to establish a concise professional narrative: where you have developed expertise, what you have contributed and why you are ready for this specific role. Use CAMP as a source of material if helpful, but edit ruthlessly. The panel already has your CV; it needs your interpretation of it.

A helpful approach is professional identity → evidence → contribution. Open with a sentence defining the kind of clinician and colleague you have become. Choose two or three themes relevant to the person specification. End by connecting these strengths with the department's challenges or ambitions. If your career has taken a less conventional route, explain how the breadth of your experience equips you for the post rather than apologising for it.

Avoid: a chronology with no message, generic passion statements, overlong claims about research unrelated to the post and personal details that do not support the question. Include: the two or three achievements that the appointing panel really needs to remember. You do not need to mention every part of CAMP unless it adds value.

Motivation and “Why this Trust?”

A good answer demonstrates that you understand the employer and have thought seriously about working there. Link three things: the role, the organisation, and your contribution. You might refer to a specialist pathway, a particular population, cross-sector work, an educational responsibility or a service-development opportunity. Be careful not to claim knowledge gained from private conversations in a way that embarrasses staff or suggests confidential information.

If the service has difficulties, acknowledge them constructively. “The waiting-list pressures are one reason I am interested: my experience in pathway redesign could help the department test sustainable improvements” is more persuasive than either pretending everything is perfect or criticising the current team.

4.3 Strengths: demonstrate your consultant-level leadership

A good consultant needs to do more than perform well personally. They also need to improve services, help colleagues perform well and turn plans into useful results. When preparing a strengths answer, therefore, think beyond a list of positive adjectives. Ask what kind of leader you would be and what the department would gain from working with you.

CPR provides a practical starting point: Change, People and Result. Can you think beyond the obvious solution, motivate and develop others, and get things done? These are complementary strengths. Someone who produces ideas but never implements them is not demonstrating the same contribution as someone who can translate an idea into a sustainable improvement. Equally, delivering results by exhausting or alienating colleagues is not effective leadership.

This does not replace the need to demonstrate clinical competence, sound judgement and the requirements of the person specification. It helps you explain the leadership qualities that sit alongside that expertise. CPR is a preparation framework, not an official marking scheme, and you do not need to announce the acronym during your answer.

Use CPR to choose meaningful strengths

Pillar	The strength you might describe	The evidence that makes it convincing
C - Change	Thinking laterally, questioning an unhelpful process and finding a workable alternative.	Explain the problem you identified, why the usual approach was insufficient and how you tested a better option. Show considered innovation, not change for its own sake.
P - People	Motivating, supporting and developing colleagues; building trust and securing cooperation.	Show how you understood others' needs, involved them in decisions, handled concerns or enabled someone else to take responsibility. Explain what improved for the team.
R - Result	Taking ownership, prioritising, following through and delivering a useful outcome.	Explain what was achieved, what you personally contributed and how you know it helped. Include follow-up or sustainability where relevant; activity alone is not a result.

Turn a label into a demonstrated capability

"I am a good communicator" leaves the panel to imagine what that means. "I am good at helping colleagues with different priorities agree a practical way forward" is more informative. It identifies a behaviour that matters in consultant work and gives you a clear route into evidence. Similarly, "I am hardworking" is less useful than explaining that you are dependable at taking an agreed improvement through to implementation and review.

For each strength, state the capability, give a short piece of evidence and explain the benefit for this post. An example need not become a complete project history. Select the decision or action that reveals the skill, mention the outcome and make the relevance clear. Use "I" for your own contribution and "we" for collective work; leadership does not mean claiming sole credit.

Answer the question actually asked

For "What are your main strengths?", two or three well-supported strengths can provide breadth, with CPR helping you select complementary qualities. For "What is your greatest strength?", choose one genuine capability and explore it more deeply. Do not answer a request for one strength with an unedited list of all three pillars. A broad strength, such as bringing people together to deliver change, can naturally demonstrate several related skills.

Match the evidence to the advertised role. A service-development post may make lateral thinking and implementation especially relevant; a post with substantial educational responsibilities may give you more scope to demonstrate how you develop others. Do not choose a strength simply because it sounds

impressive. You must be able to discuss it honestly when the panel asks for detail or feedback from colleagues.

ILLUSTRATIVE ANSWER

Three strengths, three distinct contributions

"I would highlight three strengths that I would bring to this post.

"First, I look for practical alternatives when a process is not working. In a pathway project, I helped the clinical and booking teams identify that missing referral information was creating repeated work. Rather than adding another check at the end, we tested how to obtain the necessary information earlier. The pilot reduced avoidable queries, and we used the feedback to refine the process.

"Second, I enjoy helping colleagues develop. When coordinating a teaching programme, I supported colleagues to design and lead sessions themselves, agreed the support they needed and used feedback to help them improve. That made the programme less dependent on me and gave others useful experience.

"Third, I follow things through. When coordinating a new handover template, I agreed responsibilities and review dates and addressed obstacles as they arose. We introduced it by the agreed deadline, and the follow-up review confirmed that the agreed information was being included more consistently.

"Together, those strengths would help me contribute to service improvement here while supporting the team and keeping attention on what changes in practice."

This is an illustration of structure, not a script or a set of achievements to borrow. Replace every example with your own evidence, including the actual result and any limitations.

Show leadership at the level you have actually practised

You do not need a formal management title to demonstrate leadership. A senior trainee, fellow or SAS doctor may have influenced a pathway, supported colleagues or coordinated an improvement without controlling a budget or managing the whole department. Describe the scope accurately and explain how the experience prepares you for greater responsibility. Consultant-level reasoning is not the same as inflating your previous authority.

PREPARATION EXERCISE

Build an evidence-led strengths answer

For each CPR pillar, identify one capability, one genuine example, your personal contribution and the benefit to others. Then choose the strongest two or three points for this job. Prepare a shorter version centred on your single greatest strength, and check that each claim could withstand a follow-up question about what actually happened.

4.4 Weaknesses: demonstrate insight and self-management

A weaknesses answer needs more preparation than simply naming a limitation and saying that you are working on it. It should help the panel understand a recognisable tendency in your behaviour, what happens when it is not well controlled, and the practical steps you take to manage it. At consultant level, explain the implications for colleagues, delivery and service quality as well as for yourself.

Many useful weaknesses arise from strengths that are not always well controlled. Enthusiasm encourages you to take opportunities, but can lead you to overcommit. Conscientiousness helps maintain standards, but can lead you to check or redo work unnecessarily. Being supportive makes you approachable, but can make it difficult to set boundaries. The task is not to disguise a boast as a weakness. It is to acknowledge a real downside and demonstrate that you manage it responsibly.

Choose a weakness that can be managed through behaviour

The most useful examples for this question are specific, bounded and responsive to changes in how you work. You should be able to explain what triggers the behaviour, what its consequences are, what you now do differently and what evidence suggests that this is helping. A weakness does not have to be unusual or dramatic to provide a thoughtful answer.

For a consultant applicant, the change should be credible at a senior level. "My supervisor now tells me what to do" leaves too much responsibility with someone else. A stronger account describes how you assess

capacity, negotiate priorities, delegate with appropriate support, agree expectations and review your own habits. Advice and feedback remain valuable; the important point is that you take responsibility for using them.

Choose a genuine development issue, not a trivial quirk and not an unmanaged problem that contradicts an essential responsibility of the post. Do not invent a harmless example to disguise a relevant safety concern. Conversely, an open question about weaknesses does not require you to volunteer the most distressing experience of your life. Select an example that allows a clear, honest discussion of your professional behaviour.

A familiar weakness is not automatically a cliched answer

Candidates sometimes avoid overcommitting or finding delegation difficult because they assume everyone else will say the same thing. That is not a good reason to reject a genuine example. These are recognisable pressures in professional work, and panel members may have experienced similar tendencies themselves. A familiar issue can make the explanation easier to understand and relate to.

Do not try to guess a particular interviewer's weakness or manufacture a point of similarity. Choose an ordinary, credible issue that is true of you. What makes an answer cliched is a stock label without an example, a consequence or meaningful change. "I am a perfectionist" is uninformative; explaining when your attention to detail delayed a decision, what feedback you received and how you now judge when work is ready is much more useful.

INTERVIEW INSIGHT

Relatable does not mean superficial

A familiar weakness, explained with a real consequence and a practical response, is usually a better preparation choice than an unusual weakness selected purely to sound different. You are demonstrating insight and self-management, not originality.

Why broad emotional descriptions are harder to use well

Statements such as "I worry when I get home that I may have got something wrong" or "I become frustrated with the system" can be difficult to explain within a short interview answer. They leave open questions about frequency, severity, impact and what has actually changed. A claim that you now try to worry less or be more positive does not give the panel much evidence of effective self-management.

The problem is not that experiencing worry or frustration is unusual or unacceptable. It is that a broad description of feelings may not show a bounded behaviour, a clear consequence and a practical improvement. For this question, a genuine work habit that you can describe and influence is often easier to discuss constructively. Do not repackage a serious ongoing difficulty as a minor habit; choose another truthful example when the original issue cannot be explained clearly.

Likewise, frustration with an inefficient organisation can turn into an answer about everyone else's shortcomings. If discussing your response to slow change, take ownership of an observable behaviour, such as proposing a solution before listening sufficiently to colleagues, and explain how you changed that approach. Do not make the system the supposed weakness while presenting yourself as faultless.

Examples of manageable behavioural weaknesses

Use these as prompts for reflection, not as a menu of approved answers. The suitability of each depends on your actual experience, its impact and how effectively you manage it.

Underlying strength	How it can become counterproductive	A practical way to manage it
Proactivity and enthusiasm	Agreeing to too many projects before checking the time, priorities and support required.	Review commitments before agreeing; clarify scope and deadlines; negotiate priorities; share ownership or decline additional work when necessary.
High standards and conscientiousness	Over-checking work or retaining tasks that a capable colleague could own, creating a bottleneck.	Agree the required standard, decision-making authority and review points. Provide proportionate support without redoing work unnecessarily.

Underlying strength	How it can become counterproductive	A practical way to manage it
Being helpful and approachable	Taking over routine tasks whenever someone asks, displacing planned work and limiting others' independence.	Clarify what help is needed; coach rather than automatically take over; agree boundaries while preserving routes for urgent concerns.
Thoroughness and attention to detail	Spending too long refining a low-risk document or analysis after it is already sufficient for its purpose.	Agree the intended use and completion criteria; time-limit further refinement; seek proportionate feedback and distinguish essential accuracy from cosmetic polishing.
Drive to improve services	Moving too quickly from spotting a problem to advocating a solution before understanding others' concerns.	Consult affected colleagues earlier, test assumptions, invite challenge and use a small pilot before wider implementation.

The four-stage answer structure

Keep the positive introduction brief. The answer must reach the weakness quickly, rather than sounding like another strengths answer. The sequence is: strength, counterproductive effect, example, and what you do about it.

1. State the underlying strength

Start with the useful quality that explains the behaviour. One sentence is usually enough: "I am proactive and enjoy contributing to service improvements." This provides context; it is not an invitation to list your achievements or delay admitting the downside.

2. Explain how it can become counterproductive

Name the behaviour and its impact in clear terms. For example: "That enthusiasm can lead me to agree to additional work before I have properly considered my existing commitments." Explain the cost: delayed delivery, reduced attention to a priority, unnecessary work for colleagues or dependence on you. A weakness with no consequence is unlikely to tell the panel much.

Be precise without exaggerating. "I sometimes retain too much of a project when the deadline is tight" is more informative than "I cannot delegate". Precision is not a way of minimising a serious problem; it allows the panel to understand what actually happens and in which circumstances.

3. Give an example they can picture

Use one genuine, proportionate example. Explain the work involved, what you did and how the downside became apparent. A concrete example establishes the scale of the issue and stops the panel having to imagine either a trivial inconvenience or a much more serious problem. Keep background detail short and include your own contribution rather than blaming workload, colleagues or the organisation.

Choose an example that supports consultant-level reflection. Overcommitting to two service projects with competing milestones provides a clearer route into prioritisation and shared responsibility than an account centred only on fitting revision around membership examinations. You do not have to be in a consultant post already, but you should explain what the experience taught you about senior responsibilities.

4. Explain what you do to manage it

Include what you learnt, the practical changes you made and evidence that they help. "I have learnt to say no" is a conclusion, not an explanation. Describe how you now assess requests, agree priorities, delegate, set review points or seek feedback. A brief subsequent example can show that the change has affected your behaviour rather than remaining an intention.

Do not imply that a longstanding tendency has disappeared overnight. You can explain that it still needs attention, particularly under pressure, and describe the checks that keep it manageable. The aim is to retain the useful strength while controlling its downside. Asking for feedback remains part of that process, but it should complement your own judgement rather than replace it.

PREPARATION EXERCISE

Check your chosen weakness

Write one sentence for each stage: the underlying strength; the behaviour and its downside; the example; and the changes you now make. Then expand only where the panel needs more context.

Check that the example is genuine, the consequence is visible and the response is within your control. Ask whether it shows responsibility for colleagues and delivery, rather than relying on someone else to organise you. Finish by identifying evidence of improvement and what you still monitor.

WORKED EXAMPLE

Taking on too many service projects

1 | Underlying strength

"I am proactive and enjoy taking responsibility for improvements, especially where I can see a practical benefit for the service."

2 | Counterproductive effect

"The downside is that I can agree to additional work too quickly. Unless I check my existing commitments, that enthusiasm can spread my attention too thinly and make delivery less reliable."

3 | A specific example

"While coordinating an improvement project, I also agreed to lead a substantial revision of our departmental teaching programme. I underestimated how much coordination both would need. One review milestone slipped, and colleagues had to rearrange a meeting. I discussed the problem early, agreed which work had priority and shared responsibility for the teaching programme."

4 | Reflection and management

"It taught me that being helpful means being dependable, not accepting every request. I now review my commitments before agreeing to new work, clarify the scope and time required, and agree priorities and ownership with the people involved. On a subsequent project, I negotiated a later start instead of making an immediate promise. I remain enthusiastic, but I am more deliberate about what I commit to and review my capacity when circumstances change."

The example makes a real downside visible: a milestone slipped and other people were affected. It then shows a proportionate response and a change in subsequent behaviour. It does not claim that enthusiasm excuses overcommitment, that the problem was entirely caused by the organisation, or that working ever longer hours is the solution.

WORKED EXAMPLE

Retaining too much control over a project

1 | Underlying strength

"I am conscientious and take responsibility for the standard of work delivered through projects I coordinate."

2 | Counterproductive effect

"Under time pressure, I can become too involved in checking details that a capable colleague could manage. That can make me a bottleneck and reduce their sense of ownership."

3 | A specific example

"When we revised an induction programme, a colleague was leading the resource pack, but I continued checking wording and layout beyond what was necessary. They told me that this was slowing the work and making their role unclear. I recognised that I had delegated the task without properly letting them own it."

WORKED EXAMPLE

Retaining too much control over a project

4 | Reflection and management

"We agreed the essential requirements, who could make which decisions and when a review was needed. Since then, I establish those points at the start and ask whether I am adding value before stepping back into the detail. On the next update, the colleague led the work through to completion with agreed check-ins. I still take accountability seriously, but distinguish appropriate oversight from unnecessary control."

At consultant level, delegation is not simply a way to clear your own task list. It also enables colleagues to contribute, develop and exercise appropriate responsibility. Describe proportionate supervision and clear expectations rather than swinging from excessive control to no oversight at all.

Prepare for the follow-up

A panel may ask, "Does this still happen?", "What would your colleagues say?", "How do you know you have improved?" or "What would you do when the pressure increases?" Prepare truthful, specific answers. Know which circumstances bring out the tendency, which feedback helped you recognise it and one occasion on which you managed it differently. Do not claim certainty about other people's opinions unless you have actually sought their feedback.

Avoid claiming that there was no consequence, that the weakness is entirely in the past, or that a course alone solved it. Equally, do not force a generic weaknesses answer into a different question. A question about a clinical error, a failure to meet a value or a gap in a required skill needs a direct answer to that issue, not an unrelated account of taking on too many projects.

4.5 Turn achievements into a reason to appoint you

CAMP helps you review the breadth of your contribution, but it does not decide what the panel needs to hear. The person specification and the purpose of the role make that decision. A subspecialty post may require a strong opening on clinical expertise; a service-building role may need early evidence of leadership; an academic appointment may require a clear research direction. Do not give each CAMP heading equal time simply to complete the acronym.

For each claim, explain its significance. "I have worked in a tertiary centre" describes a location. "I have developed experience of coordinating complex decisions across several specialties" describes a capability. Follow it with evidence of what you personally did and acknowledge the limits of your responsibility. A consultant-level account is not an inflated account of a trainee role.

Present clinical expertise without a catalogue

Explain the range of practice you can contribute, the complexity you have managed, the judgements you make and how you work with others. Highlight the part of your expertise that solves a genuine need in the advertised role. A list of procedures or rotations may establish exposure but does not, on its own, show sound judgement, dependable practice or readiness to supervise.

You can discuss a complex clinical contribution without giving a detailed clinical case. Explain the nature of the challenge, how you coordinated information or expertise, how you involved the patient and what you learnt. Be precise about decisions made independently, jointly or under supervision. Credibility depends on that distinction.

Make motivation reciprocal

A convincing "Why this job?" answer explains both what attracts you and what the employer gains. The clinical opportunities, population, team or teaching role may be attractive; your evidence should show how you would contribute to them. Location and family circumstances can be genuine reasons, but usually do not explain why the organisation should select you over another eligible candidate.

Avoid flattery that could describe any employer. "The trust has an excellent reputation" is less informative than a specific interest in its pathway, population or collaborative model. Do not exaggerate what you know from a short visit. Say what you would like to understand further.

Handle a development gap with a plan

A new consultant will not arrive with every skill fully developed. Distinguish a manageable development need from an essential requirement you do not meet. Where the gap is compatible with the post, state it clearly, explain relevant transferable experience and describe the support or development required. Do not promise mastery without supervision, time or opportunity.

IN PRACTICE

A limited formal leadership title

A candidate worries that they have never held a departmental leadership post. They nevertheless coordinated a change in trainee induction, negotiated protected teaching time and supported a colleague to take over the programme. The interview answer focuses on those actions and outcomes rather than apologising repeatedly for the absence of a title.

The limit remains clear: this is evidence of influence and delivery, not a claim to have managed a whole service or held a budget.

Prepare a contribution, not a slogan

Write three sentences beginning "The service would benefit from my..." Complete each with a different capability and evidence. Then test whether the job description supports that benefit. This is a preparation exercise, not wording to repeat mechanically. Its purpose is to move from self-description to an explanation of value.

PUT IT INTO PRACTICE

Build your professional introduction

Use CAMP to select three relevant capabilities. Attach one piece of evidence and one service benefit to each. Practise a short and a longer version.

Self-check: Does the answer explain why this post and why you, rather than merely listing achievements?

05
Evidence-led answers: STAR and themes



Select real examples, organise them around meaningful challenges and make your skills and learning explicit.

01 STAR: Result / Reflect
02 Chronology versus themes
03 Prepare and adapt evidence

S	T	A	R
Situation	**Task**	**Action**	**Result / Reflect**
Only the context the panel needs.	The aim and your responsibility.	Decisions, behaviours and rationale.	Outcome, limitations and learning.

5.1 STAR: Situation, Task, Action, Result / Reflect

The STAR approach used in this handbook is Situation, Task, Action, Result / Reflect. It is useful for behavioural questions asking you to describe something you did. In consultant interviews, the Action is usually the most revealing part: what you decided, who you involved, why you chose that approach and how you handled resistance or uncertainty. The Result should include both measurable impact where available and what you learnt.

In this handbook, R means Result / Reflect. The result tells the panel what changed, with evidence where available; reflection demonstrates insight into what worked, what did not and how your practice developed. The Action section must show your personal choices rather than a sequence of meetings. Do not convert this into a rigid script: you may give a very short situation and task, then spend most of the answer on action, outcome and learning.

Step	What belongs in it	Typical error
Situation	Just enough context to understand the difficulty	Two minutes of background
Task	What had to change and what you personally owned	Confusing the team's goal with your responsibility
Action	Specific choices, communication, barriers and rationale	Listing meetings without explaining your impact
Result / Reflect	Outcome, measures, feedback, learning and transferability	Saying only “it went well”

An example in outline: Asked about handling resistance to a change, briefly explain the pathway problem and the aim; describe listening to those affected, testing options, agreeing measures and adapting implementation;

give an honest account of the outcome; finish with the lesson about involving colleagues early. This is a structure for finding your own story, not a model answer.

Using the Result / Reflect stage effectively

Use STAR, Situation, Task, Action and Result / Reflect, where the interviewer asks for evidence of something you have done: “Tell us about a change you introduced.” The task and context should be short enough to leave substantial time for your own decisions and actions. Do not hide behind “we” when asked what YOU did, but do not claim sole responsibility for a multidisciplinary success. Use an honest result, even when it was mixed.

The R can emphasise the measurable result, or what you reflected on and learnt, depending on the question. Ideally include both: state honestly what happened, including limitations, and then identify the learning and what you would change. Reflection must not replace the actual outcome. In an unsuccessful project, a credible explanation of your decision-making and subsequent changes may reveal more maturity than an exaggerated success story.

Example: the same project told at three different levels

Weak: “I led a multidisciplinary project and we improved efficiency.” This tells the panel neither what you led nor whether it improved anything meaningful. Developing: “We had a problem with delays, so I arranged meetings and introduced a new template. Staff found it easier.” Better: “Our referrals often arrived without information needed for triage. I reviewed a sample, agreed the essential information with nurses and referrers, piloted a shorter template, and monitored completeness and rework before scaling it. Completion improved during the pilot, although we identified a remaining problem for one referral route. I learned that simplifying a form only helps when it fits the real workflow.” This remains illustrative; a candidate should use an authentic project and accurate outcomes.

Reflective questions that transform a story

Why did you choose that intervention over other options? Who disagreed, and what did you learn from them? Which data were reliable and which were missing? What unintended effect did you watch for? What was the decision you personally made? How did you know the project mattered to patients or staff? What would you do differently with consultant-level responsibility? These questions add depth without demanding a rehearsed script.

Why a strictly chronological STAR answer can be disappointing

STAR is often taught as a sequence: first explain the situation, then the task, then describe each action in order, and finally give the result. That can be helpful when retrieving a story from memory, but it is not necessarily the most persuasive way to present a prepared example. People tend to remember projects chronologically: the first meeting, a discussion with a manager, the email that followed, a delay, another meeting and so on. Many of those events were necessary at the time but tell an interview panel little about the candidate’s skills.

A chronological narrative can therefore become lengthy and full of incidental detail. The panel is left to infer whether you can organise a change, engage colleagues, exercise judgement or sustain improvement. A candidate may have done all those things, yet give an answer dominated by what happened next. Time is spent recounting the process rather than demonstrating the abilities the question was designed to assess.

A stronger alternative for a prepared example: organise it by themes

For examples you can reasonably anticipate, it is often better to begin with a brief overview of the situation, the purpose of the work and the eventual outcome. This gives the panel its bearings immediately. Then move through two or three deliberately chosen aspects of the example. Each section should illustrate a different skill or dimension of your contribution, rather than simply a different period in the project’s timeline.

Suppose you are asked: “Tell us about a significant change you introduced.” You might open by explaining that referrals were repeatedly delayed, that you helped redesign the triage pathway with the multidisciplinary team, and that the pilot reduced avoidable rework while maintaining appropriate safety checks. You can then organise the substance of the answer around three challenges: designing the logistics and processes; securing team engagement and buy-in; and making the change sustainable.

EXAMPLE

Three purposeful sections:

(1) Logistics and processes — mapping the existing pathway, identifying bottlenecks, testing feasibility, clarifying responsibilities and safeguarding patients. This demonstrates analysis, planning and delivery.

(2) People and buy-in — listening to colleagues, addressing legitimate concerns, involving nursing and administrative staff, and finding common ground. This demonstrates communication, influence, teamwork and leadership.

(3) Sustainability — agreeing measures, reviewing unintended consequences, building the new process into routine practice and assigning ownership. This demonstrates accountability, evaluation and long-term thinking.

Notice that this approach does not abandon STAR. The opening provides the Situation and Task; the three themes explain the Action; and the outcome and closing reflections complete the Result / Reflect element. What changes is the organisation of the middle of the answer. Rather than telling the panel everything in the order it happened, you select and arrange the most revealing evidence.

How to prepare thematic examples

This technique only works well when the example has been dissected in advance. Start by writing down the main facts and what actually happened. Then ask: What were the two or three hardest or most important challenges? Which decisions were mine? What other approaches did I consider? What did I do that a less effective colleague might not have done? What did the outcome show? Finally, identify the skill each section demonstrates. If two sections demonstrate exactly the same thing, consider combining them or choosing a more revealing angle.

The themes should follow the substance of the example, not a rigid template. A conflict example might be organised around understanding the different perspectives, managing the difficult conversation and rebuilding the working relationship. A clinical governance example might focus on recognising risk, responding fairly to those involved and improving the system. An education example might cover identifying learning needs, developing the teaching intervention and evaluating its impact.

PREPARATION INSERT

Dissect your evidence before the interview

For each of your strongest examples, write five lines:

(1) the situation and objective in one or two sentences;

(2) the headline outcome, including limitations;

(3) challenge or theme one and the skills it demonstrates;

(4) themes two and three, each with distinct evidence of your contribution;

(5) what you learnt, what you would do differently and how this prepares you for consultant responsibility. Rehearse explaining the themes naturally, without announcing them mechanically.

When you have to think of an example on the spot

Not every question can be anticipated. If the panel asks for an example that you have not prepared, you may not have time to disentangle the story into neat thematic sections. In that situation, a straightforward chronological STAR answer may be the safest and most natural way to stay coherent. Give only the context the panel needs, move efficiently through the important decisions, avoid unnecessary names or minor events, and make clear what you personally did.

The closing reflection becomes particularly important in an improvised answer. Do not merely say, “It went well” or “I learnt the importance of communication.” Explicitly tell the panel what the example reveals about your abilities: perhaps that you can identify the real problem, negotiate between different interests, make a difficult decision, support colleagues or follow through until a change is embedded. Then add a credible lesson or limitation. This final step helps the panel recognise skills that may have been less obvious in the chronological narrative.

INTERVIEW INSIGHT

Choose the structure that fits the situation

Prepared example: overview and outcome → two or three skill-led themes → Result / Reflect.

Unexpected example: concise chronology → result → deliberate reflection identifying the skills demonstrated. Both should remain truthful, selective and responsive to the question.

What not to do

Do not force a thematic format onto a simple event that can be explained clearly in a minute. Do not announce skills without evidence ("This showed excellent leadership") or retrospectively invent tidy stages that never existed. Do not reveal identifiable patient or colleague details unnecessarily. And do not sacrifice the outcome: the panel still needs to know whether the work achieved anything useful, what evidence supports that conclusion and what you learnt where the result was mixed.

5.2 The evidence bank: six stories that travel well

The best evidence bank contains adaptable examples, not one memorised response for every possible question. Prepare stories you can use to discuss several competencies while changing the emphasis to fit the question.

Story type	Evidence to prepare	Other questions it may answer
Leadership/change	Influencing people, overcoming barriers, measuring outcomes	Teamwork, service development, resilience
Conflict/ relationship	Listening, fair discussion, agreed way forward	Communication, self-awareness, values
Quality/patient safety	Risk recognition, response, learning, improvement	Governance, professionalism, accountability
Teaching/ development	Identified need, method, feedback, impact	Leadership, mentoring, team culture
Innovation/initiative	Problem, options, implementation, evaluation	Productivity, system working, future vision
Setback/feedback	A genuine difficulty, change made and learning	Weaknesses, reflection, adaptability

For each story, write a 30-second headline, a two-minute version and one sentence explaining relevance to the job. Add facts or figures only where you can substantiate them. Check that you can say what you did personally and what the team achieved collectively.

5.3 Dissect one example before rehearsing it

Choose a genuine example and write the full chronology privately. This is your source material, not your interview answer. Mark the decisions you made, the obstacles that mattered and the points at which your approach changed. Remove names, incidental meetings and technical detail that the listener does not need. What remains should reveal a small number of meaningful challenges.

For a change project, those challenges might be designing the process, securing colleagues' support and sustaining the improvement. For a conflict, they might be understanding different interests, reaching a workable agreement and restoring collaboration. For teaching, they might be diagnosing learning needs, adapting delivery and evaluating whether learning transferred into practice. The headings must emerge from the example rather than being imposed on every story.

Give the outcome early without overselling it

An overview can include the situation, the purpose and the headline outcome: "I helped redesign an unreliable referral process. The pilot reduced missing information, although one referral route remained problematic." The panel now understands the direction of the story and the limits of the result. You can spend the middle of the answer explaining how you approached the challenges instead of building suspense about what happened.

An early outcome must be supported later if it is important. Be ready to explain the period measured, the denominator, what was compared and what you can reasonably attribute to the intervention. "Improved" is not a substitute for a measure; an impressive percentage without its context may be less useful than a modest but well-explained result.

Choose evidence within each theme

A section on team engagement should show more than that you held a meeting. What did colleagues object to? What did you change in response? Which concern could not be accommodated, and how did you explain that? A section on sustainability should show who owned the process, how newcomers learnt it and how deterioration would be detected. Each section should leave the listener with a different, identifiable capability.

WORKED EXAMPLE

The same project, two organising principles

Chronological opening: "First I spoke to my supervisor, then I emailed the team, and after two meetings we arranged another discussion with the manager..."

Thematic opening: "We improved the reliability of referral information through three strands of work: simplifying the process, agreeing it with the people who used it and building review into routine practice. My main contribution was coordinating those strands."

The second version still needs concrete evidence. Its advantage is that the structure gives every detail a purpose. It is not permission to replace facts with impressive headings.

Keep a truthful fallback for unexpected questions

When an unanticipated question brings a real event to mind, chronological STAR may be the clearest structure available. Pause, establish the situation briefly and identify the decisions you made. Then give the outcome and a deliberate reflection: what the example demonstrates, what you learnt and what you would now change. You are constructing the answer as you speak, not inventing the event.

Never manufacture an example to fit an attractive structure. When your closest experience is not identical to the question, say so: "I have not led that exact situation, but a relevant example of influencing across teams was..." Explain the limits of the comparison rather than disguising them.

Rehearse alternative questions, not alternative scripts

Use the same example for two different practice questions and notice what must change. A leadership question may require more on influence; a quality-improvement question may require more on measurement; a failure question may require more on your initial assumptions. Retain the facts and change the emphasis. That is adaptive preparation rather than memorisation.

06
Trust values and values-based interviews



Translate values into observable behaviour, including honest examples of when your behaviour fell short.

01 Positive and counter-examples
02 Behaviour under pressure
03 Values-based questions

6.1 From stated values to lived behaviour

Every trust has its own stated values, often expressed through words such as compassion, respect, teamwork, excellence and inclusion. Those words matter only when candidates translate them into observable decisions and behaviour. Read the employing organisation's exact values and any behavioural framework before the interview. Do not assume that two trusts using the same word define it in the same way.

What values-based interviewing actually tests

A values-based interview may use questions about past behaviour, hypothetical scenarios, role plays, or follow-up probes. The assessor is not simply checking whether you can recite the values. They want evidence of how you behave when values become difficult: when there is a power imbalance, competing priorities, an unpopular decision or a risk of harm. The same answer can display several values, but it should remain specific and credible.

Prepare an example for every trust value — and an honest counter-example

Build a two-sided values evidence bank. For each local value, identify (1) an occasion when your behaviour demonstrated it and (2) an occasion when you fell short of your own standard or could have demonstrated it more effectively. Use STAR with R as Result / Reflect. In the second example, take responsibility, explain any immediate correction, what you learnt, how your behaviour changed and how you know that the change was sustained. Avoid inventing a failure merely to appear reflective.

IN PRACTICE

When listening was missing

A trust values "listening". A candidate describes introducing a rota change after consulting senior colleagues but not junior staff. Complaints followed.

A mature response acknowledges the omission, explains how the candidate listened and amended the process, and shows that future consultations included those most affected. "I now ask who is missing from the conversation" is more persuasive than claiming to have always been inclusive.

A practical values matrix

For each value, write the exact wording from the trust website; the behaviours the trust associates with it; a real example of success; a real example of learning; and one sentence about how you will model the value as a consultant. For respect, think of delivering difficult feedback; for compassion, a demanding patient

interaction; for collaboration, an interdepartmental disagreement; for inclusion, removing an access barrier; for excellence, responding to variation in outcomes.

How to talk about a time you failed to demonstrate a value

Choose an authentic, bounded example. It need not involve serious harm. Do not choose an episode that exposes identifiable patients, unresolved serious misconduct, or a current safety risk. Avoid externalising the blame (“I was let down by the team”), giving an artificial weakness (“I care too much”), or describing a serious departure from professional standards as if reflection alone resolved it. If the event involved reportable harm, describe the actual escalation, openness and governance actions taken, without disclosing confidential details.

Typical values-based questions

“Tell us about a time when you challenged behaviour that was inconsistent with our values.” “When have you been less compassionate or inclusive than you intended?” “Describe a disagreement in which you changed your mind.” “How would you respond if a high-performing colleague repeatedly treated staff disrespectfully?” The most convincing answers make the tension visible, describe how you decided what to do, and include the effect on others.

INTERVIEW INSIGHT

A statement such as “I am always respectful” is hard to verify and unlikely to be literally true. A carefully chosen example of listening, changing course and learning often provides stronger evidence of integrity.

6.2 Prepare values as evidence of behaviour

Begin with the employer's current values and any accompanying behaviour framework. The words on a website are only the starting point. A value such as respect may be expressed through listening, how decisions are explained, how disagreement is handled and whether people are included. A value such as excellence may involve seeking feedback, recognising limitations and improving a process rather than claiming never to make mistakes.

For each value, prepare one positive example and one genuine occasion when your behaviour did not fully match it. These need not be dramatic incidents. A rushed interaction, an assumption about what a colleague needed or a failure to involve a group early can provide meaningful material if you take responsibility and show change. Do not convert every weakness into a flattering account of how hard you work.

Make the behaviour specific

"I am compassionate" is a belief about yourself. An example should show what you noticed, how you explored the person's needs, what you changed and how you checked whether it helped. "I am inclusive" requires evidence of whose perspective was missing and how you made participation possible. "I work well in teams" needs a decision or behaviour, not merely membership of a multidisciplinary group.

A useful preparation question is: what might someone else have seen or heard me do? It moves the answer from values as adjectives to values as observable conduct. Include your reasoning, because the same action can have different meanings in different circumstances.

Explain a failure without defending it away

A reflective account should establish the expectation, identify your own behaviour and describe its effect. Then explain how you recognised the problem, how you responded and what changed afterwards. Context can explain pressure, but should not erase responsibility. "The department was busy" may be true; it does not explain why you failed to listen or why the effect on a colleague did not matter.

Avoid a superficial apology followed by an immediate claim that everything was fine. What did the other person need? Did you revisit the decision or simply regret your tone? What would they say about your subsequent behaviour? Where you do not know how they experienced the repair, acknowledge that rather than assuming forgiveness.

IN PRACTICE

Falling short of respect

During a pressured meeting, a candidate interrupted an administrative colleague and dismissed a concern about appointment letters. The concern later proved important. In the interview, the candidate identifies both the discourtesy and the poor decision-making: they had assumed that a non-clinical colleague's contribution was less relevant.

They describe apologising privately, reopening the issue in the group with appropriate credit and changing how they invite contributions. The reflection is not "I am now always respectful". It is that status and time pressure can distort whose evidence is heard, and that they have developed a more deliberate way of checking this.

Values can create competing demands

Compassion does not mean agreeing to every request. Openness does not permit disclosure of confidential information. Teamwork does not require silence about unsafe practice. A mature answer identifies the competing duties and explains a proportionate response. For example, supporting a colleague in difficulty may involve both listening and restricting an unsafe activity through the proper arrangements.

Panels may explore this through scenarios rather than asking you to name a value. "A well-liked colleague repeatedly makes dismissive comments" tests what you will tolerate, how you act and whether you follow through. Do not simply quote the trust's respect value. Show the conversation, the standards, the support and the action if behaviour continues.

Connect personal examples with consultant responsibility

A junior example can be valuable, but explain what greater responsibility would change. As a consultant you may set the tone of a meeting, allocate opportunities, supervise a colleague or hold a leadership role. Reflection should address that influence. It is not enough to say you would continue to be a nice person; explain how you would create fair processes and respond when behaviour falls below expectations.

PREPARATION EXERCISE

Build a values matrix

For each exact trust value, record: the behaviour it requires; a positive example; a counter-example; your personal action; the effect on others; and evidence of changed practice. Test the examples against a follow-up question: "What would the other person say you did?"

Keep the matrix brief. Its purpose is to prompt genuine recollection and analysis, not to produce a separate memorised speech for every possible value.

Avoid confusing values with similarity

Values-based recruitment should concern relevant behaviour, not whether someone shares the panel's background, accent, hobbies or preferred personality. Explain the values through your actions rather than attempting to perform a cultural stereotype. Equally, do not treat disagreement as evidence that another person lacks the organisation's values. Two colleagues may share the same concern for patients and differ about how to act.

07
Leadership through Change, People and Result



Show how you think differently, bring people with you and deliver worthwhile results.

01 Think laterally	02 Motivate and develop others	03 Deliver and sustain results
C **Change** Think laterally and improve services.	**P** **People** Motivate, support and develop others.	**R** **Result** Get things done and show impact.

7.1 The three pillars in practice

At ISC Medical, CPR means Change, People and Result. It is a way of assessing the breadth of leadership rather than a fixed script for answering every question. CHANGE: think laterally, challenge assumptions and lead sensible improvement. PEOPLE: motivate, support and develop colleagues while taking difficult conversations seriously. RESULT: turn intentions into safe, measurable and sustainable outcomes. Strong consultant leadership integrates all three: a clever change that loses the team is fragile; a happy team without progress is not enough; a quick result that damages safety or trust is not success.

A useful leadership example should contain evidence of all three pillars, even when one is particularly prominent. What did you seek to improve or do differently (Change)? How did you involve people, understand their concerns and support them (People)? What happened, how do you know, and what remains to be done (Result)? A project can be technically successful yet fail to show effective leadership if the team was alienated. Equally, a pleasant, inclusive process is incomplete if no important problem is resolved.

Consider a clinic pathway with unacceptable delays. CHANGE: you investigate the reasons for delay rather than assuming that people simply need to work faster; you invite colleagues to challenge the existing pathway and test an alternative. PEOPLE: you explain the purpose, actively listen to nursing and administrative staff, agree responsibilities, protect training needs and respond constructively to resistance. RESULT: you use baseline data, test the redesigned pathway, monitor waits and safety, acknowledge unintended consequences and agree what will be sustained. In your interview, the critical material is your judgement, not the name of the project.

CPR also exposes incomplete answers. If you describe Change without People, the panel may worry that you impose ideas. People without Result may suggest insufficient accountability. Result without Change may reflect effective delivery but limited strategic or creative leadership. The framework helps you show a balanced leadership approach, not claim that every change must be novel or every outcome immediately measurable.

Change: thinking laterally and moving a service forward

Change begins with recognising that the current way of working may not deliver the best outcomes. That recognition should be based on evidence: waiting times, patient feedback, incidents, unwarranted variation, clinical outcomes, staff experience or an emerging national priority. A mature leader distinguishes a genuine problem from a personal preference. If someone says, “We have always done it this way,” the effective response is not to dismiss their experience, but to ask what the present arrangement achieves, where it fails, and whether there is a safer or better alternative.

Thinking laterally means challenging assumptions rather than merely proposing a larger clinic, a new rota or a new form. Could a referral be managed differently? Is repeated follow-up clinically necessary? Are tasks sitting with the wrong part of the multidisciplinary team? Could the patient receive a better service in a different setting? A sound improvement proposition defines the problem, maps the pathway, listens to users and staff, tests several options and thinks about constraints such as workforce, space, training, digital systems and finance.

Change also requires political and emotional intelligence. Those asked to change may fear an increase in workload, a loss of professional identity, reduced autonomy or previous failures being repeated. Do not label every objection as resistance. Some objections reveal a genuine safety issue, a resource dependency or an inequality the change team overlooked. Explain how you would engage critics early, distinguish non-negotiable safety standards from flexible methods, and test the change on a manageable scale before wider adoption.

People: motivating, supporting and developing others

People leadership starts with understanding what enables colleagues to do their best work. Listening, fairness, clarity, psychological safety and visible follow-through matter more than repeatedly saying you have an “open door.” Motivation is not one-size-fits-all. A newly appointed doctor may value confidence, feedback and supervision; an experienced nurse may value autonomy and recognition of expertise; a pressured administrator may need realistic priorities and functioning systems. A consultant who ignores these differences may inadvertently create frustration while trying to be encouraging.

The panel may test whether your support extends beyond easy colleagues. Can you give constructive feedback early rather than avoiding the conversation? Can you distinguish a performance gap from lack of resources, inadequate supervision, illness or misconduct? Can you be compassionate without lowering essential standards? A credible answer combines a private and respectful conversation, objective examples, exploration of underlying causes, an agreed support or improvement plan, review points, and proportionate escalation where necessary. Patient safety, fairness and organisational procedures remain central.

Developing others is more than delivering teaching sessions. Strong examples describe how you identify learning needs, make supervised responsibility possible, give specific feedback, recognise achievement, create opportunities and assess whether competence and confidence improved. A good consultant also develops other leaders: colleagues who can question decisions constructively and run improvements without constant personal direction.

Result: doing what you said you would do

Results leadership is about disciplined delivery. A leader must turn a reasonable ambition into priorities, ownership, milestones, resources and measures. If the aim is to reduce delay, what exactly is the baseline? What is within your influence, what depends on other teams, and how will you know whether patients benefited? Which measures show progress, and which balancing measures show that harm has not simply been shifted elsewhere?

Avoid confusing activity with impact. “We introduced a new pathway” describes an action. “We reduced the median wait while monitoring reattendance and patient experience” begins to describe an outcome. It is equally valid to explain that a project achieved only partial results: specify what worked, what was difficult, what you changed and what you would do next. Panels may trust a candid, thoughtful account more than an implausibly flawless success story.

Accountability does not mean taking all the credit. Describe your personal decisions and contribution, then acknowledge the multidisciplinary colleagues who made delivery possible. Where change has not yet produced measurable results, distinguish a well-specified plan, an early process measure and an established patient outcome. Do not invent financial savings or claim improvements that were not evaluated.

Putting all three together in a two-minute leadership answer

A coherent response might begin: “I was concerned that our referral-to-review interval was rising, and I wanted to understand the causes before proposing a solution.” That establishes the need for Change. Continue by describing your analysis and lateral thinking: for example, whether unnecessary appointments, unclear triage or missing information were creating repeated work. Then explain the People element: which professional groups and patients were involved, how concerns were handled, how a colleague was supported to take ownership, and what you did when people disagreed. Finish with Result: what was piloted, what measures were used, what improved or did not, what was learnt and how it would influence your approach as a consultant.

Panel challenge: “What would you do if your colleagues opposed your proposal?” A weaker answer says, “I would explain the evidence and bring them on board.” A better answer explores whether the opposition reflects a clinical concern, insufficient involvement, workload, previous experience or mistrust; tests whether

the proposal is sound; adapts the plan when justified; and remains clear about the outcome and the safety boundaries. The three pillars must support one another.

7.2 Leadership: demonstrating Change, People and Result

Leadership is the process of helping people move towards a shared goal. A formal leadership post can provide evidence, but leadership also occurs in a ward round, clinic, MDT, improvement project or difficult conversation. The difference lies in how you make decisions, involve others, create clarity and follow through. Panels are interested in what you actually changed, not simply which committees you attended.

Good leadership balances several behaviours. Compassionate leadership involves listening, understanding, empathy and helping, without avoiding standards or accountability. Inclusive leadership creates conditions in which diverse voices can contribute and concerns can be raised safely. System leadership recognises that the patient pathway crosses departmental and organisational boundaries and that influence often matters more than formal authority.

When asked about your leadership style, resist simply choosing a label such as “democratic”. Explain how your approach changes with the situation. A serious safety risk may require immediate direction; a service redesign may require wider consultation and co-production. The key is to show how you remain transparent, respectful and accountable in both circumstances.

A leadership evidence bank

Choose at least three examples: one where you led a change, one where you influenced without authority, and one where you supported someone else. For each, record the problem, your contribution, the stakeholder groups, the barriers, the outcomes and the learning. A useful challenge is to explain the same example in both 45 seconds and two minutes without losing the essential message.

What the panel really means by “Are you a leader?”

A consultant is expected to lead without always having formal authority. Consultants influence clinical standards, set the tone of their working environment, help colleagues navigate uncertainty, and negotiate priorities with managers and professional peers. An interview panel therefore looks for evidence that you can mobilise others around a worthwhile purpose, not just a list of committee posts. Leadership can be demonstrated by a registrar who notices a recurrent failure, persuades colleagues to investigate it, supports a small test of change and measures the effect. Conversely, chairing a committee for several years tells the panel little unless you can explain what improved as a result.

Prepare at least three examples: one that emphasises Change (creative service redesign), one that emphasises People (developing a colleague or navigating a difficult relationship), and one that emphasises Result (delivering a project despite constraints). For each, check whether you can describe all three pillars. Consider what you genuinely controlled, what you influenced and what was accomplished by the wider team. Being accurate about your contribution demonstrates maturity.

A leadership dilemma: the popular change that harms outcomes

Your team suggests replacing most routine follow-up consultations with digital messages. Staff initially welcome the proposal because it could free clinic slots. But a pilot finds that some patients struggle with digital access and a small number return later with avoidable deterioration. An inexperienced leader might push ahead because the waiting-list metric improved. A CPR-led response asks whether the Change truly benefits patients, involves patients and colleagues in redesigning the approach (People), and widens the measurement set to include clinical safety, inequality, reattendance, patient understanding and staff workload (Result). There may still be a place for digital follow-up, but not as an indiscriminate replacement for clinically necessary review.

Distinguishing leadership from management

Leadership and management are complementary rather than opposing functions. Leadership helps determine direction, create commitment and navigate uncertainty. Management makes the service dependable through staffing, rotas, systems, standards, resources, supervision and follow-through. A consultant needs both: an inspiring vision without a viable operational plan will frustrate colleagues, while efficient administration without a sense of purpose can preserve an outdated service. When asked about your leadership style, describe how you adapt it to the people, task and level of risk, rather than claiming a single fashionable label explains all situations.

Exercise: build a genuine CPR evidence bank

Write one example under each heading: Change, People and Result. For every example answer six prompts: What problem was important? What alternatives did you consider? Whose perspective changed your

thinking? What decision did you personally make? What evidence shows the outcome? What would you do differently as a consultant? If you struggle with the last two questions, the example may still be useful, but needs more analysis before it becomes convincing interview material.

7.3 Use CPR to explain the mechanics of leadership

CPR is a way of examining leadership, not a checklist of flattering characteristics. Change asks whether you can see a better way and make it workable. People asks how you motivate, support and develop others. Result asks whether anything worthwhile is delivered. A persuasive example connects all three while showing the particular challenge you faced.

Change: lateral thinking with practical discipline

Thinking laterally does not mean proposing an unusual solution simply to look innovative. It means questioning the assumption that limits the available options. If patients wait because information is incomplete, more appointments may not be the only answer. If teaching attendance is poor, adding more teaching sessions may not address rota design or relevance. Explain how you identified the assumption, considered alternatives and tested a different approach.

A good change account distinguishes your idea from the evidence supporting it. What did the team already know? What did you learn from people doing the work? What would have led you to abandon the idea? A candidate who can describe a sensible rejected option often reveals more judgement than one who presents the final solution as obvious from the start.

People: motivation, support and development are different

Motivation involves understanding what makes the work worthwhile and what gets in the way. A colleague may resist a proposal because of workload, uncertainty, previous failed initiatives or a legitimate concern about patients. Explore the reason before assuming that they lack enthusiasm. Explain the purpose, invite meaningful input and make the contribution achievable.

Support means providing what people need to deliver safely: clarity, resources, supervision, feedback or access to help. Development means increasing their future capability. Delegating a task with an agreed purpose, boundaries and review points can do all three. Simply giving someone extra work and describing it as an opportunity does not.

Result: define success before celebrating it

A result can include a measurable service improvement, a more reliable process, a stronger team or a colleague's development. It should still be evidenced. Distinguish completing an activity from achieving its purpose. A new guideline is an output; more reliable practice is the intended outcome. A full teaching programme is an output; improved learning or performance is the intended outcome.

Explain what happened when progress was slower than expected. Did you revise the plan, secure a decision, stop ineffective work or make a limitation visible? Taking responsibility includes being honest about what was not delivered and ensuring that unresolved issues have an owner.

IN PRACTICE

Leadership without doing everything yourself

A candidate previously rescued a teaching programme by preparing every session personally. It succeeded briefly but became dependent on them. In a later programme, they agreed shared objectives, developed new faculty members and put a simple feedback and handover process in place.

The second example shows more than delegation. It combines a different operating model, support for other teachers and a programme that can continue without one person. The candidate can also acknowledge what the first attempt taught them.

Adapt style without abandoning principles

An immediate safety problem may require a clear instruction; redesigning a pathway may require time for consultation. Describe why a particular approach fits the urgency, available expertise and consequences. "I use a democratic style" is not enough when a decision cannot wait. "I am decisive" is not enough when colleagues hold information you need.

The consistent principles are clarity, respect, accountability and attention to outcomes. Your method can change while those principles remain stable. In an interview, use a short example of changing your approach in response to a team's needs rather than reciting a list of leadership styles.

PUT IT INTO PRACTICE

Check your leadership evidence

Take one example and examine Change, People and Result. Identify the weakest pillar and the evidence needed to explain it honestly.

Self-check: Did you help others develop and create something that can continue without you?

7.4 Compassionate leadership: understanding people and enabling good work

Compassionate leadership means noticing when people are struggling, understanding what is contributing to their difficulty and taking useful action. It is more than politeness, sympathy or saying that your door is always open. For a consultant, it means combining concern for individuals with responsibility for patients, colleagues and the service. Supporting one person must not mean quietly transferring an unreasonable burden to everyone else.

A useful four-part model describes attending, understanding, empathising and helping. These behaviours are used in health-care leadership teaching, including the work of Michael West and The King's Fund. They are a guide to a meaningful response, not another acronym to recite. The distinctive question is what you actually changed after listening.

Attend: notice and listen before deciding

Make time for a private conversation when someone appears unusually withdrawn, repeatedly stays late or tells you that they cannot cope with a demand. Begin with an observation rather than a diagnosis: "I have noticed that you have stayed behind after several clinics. How is the workload at the moment?" Give the person space to explain without interrupting, comparing their experience with your own or immediately proposing a resilience course.

Pay attention to less visible colleagues as well as those who confidently request help. A new colleague, an internationally trained doctor, a staff member working nights or a person in a non-clinical role may not have the same access to informal support. A predictable check-in can be more useful than an invitation that depends on them approaching a senior consultant first.

Understand: establish the causes and the effect

Explore whether the problem concerns workload, unclear responsibilities, missing skills, inefficient systems, difficult relationships or circumstances outside work that the person wishes to disclose. Do not assume that visible distress proves poor competence, or that high performance means someone needs no support. Ask what has already been tried and what help the colleague believes would make the greatest difference.

Check your understanding: "It sounds as though the extra referrals and the lack of administrative support are the main pressures, rather than the clinic itself. Have I understood that correctly?" Where the situation involves other people, obtain relevant perspectives fairly. Listening seriously does not require accepting every interpretation without examining it.

Empathise: acknowledge the experience without taking over

Recognise the effect on the person without minimising it. "That sounds difficult, especially when you are trying to keep the service running" is different from "Everyone is busy". Avoid promises of complete confidentiality if there may be an immediate safety concern. Explain sensitively when information needs to be shared and involve the colleague in that discussion wherever possible.

You are acting as a colleague and leader, not as the person's therapist or treating doctor. Offer appropriate routes such as occupational health, staff support, mentoring or the relevant line manager when needed. Do not press for private medical or personal details that are unnecessary to agree a work-related response.

Help: agree a proportionate action and follow it through

Translate understanding into an achievable plan. This might involve clarifying priorities, providing supervision, restoring administrative support, reviewing a rota, removing duplicate work or renegotiating a deadline. Ask who will do what and when you will review the effect. When you cannot authorise the solution, make the case to the person who can and keep the colleague informed.

Do not promise staffing or resources outside your authority. Be clear about what can change immediately, what requires agreement and what cannot yet be resolved. A difficult but honest conversation is more useful than reassurance that leads nowhere. Follow-up matters: an offer of help is not evidence that the problem was addressed.

Use CPR to connect compassion with delivery

Change: ask whether the way the work is organised is creating avoidable pressure, and involve the team in a better approach. People: listen, support, include and develop colleagues rather than expecting them to absorb every problem. Result: check whether the action improves both the colleague's experience and the reliability of the service. Compassion is therefore relevant to all three pillars of CPR, not only People.

This also explains the relationship with psychological safety. Compassion concerns how you recognise and respond to other people's difficulties. Psychological safety concerns whether people feel able to ask, challenge and acknowledge uncertainty without humiliation or unfair consequences. Positive culture is the broader pattern of what is expected, rewarded and tolerated. The ideas support one another but are not interchangeable.

WORKED CASE

The colleague who always says yes

A consultant colleague has become the default person for extra clinics and is now missing agreed service-development deadlines. A purely sympathetic response is to say that you appreciate how hard they work. A useful leadership response is to examine what they are carrying, clarify which commitments matter most and agree a fair redistribution or reprioritisation with the responsible manager. Check the consequences for the rest of the team. Review whether deadlines, workload and the colleague's ability to recover have improved, rather than praising them for continuing to work excessive hours.

7.5 Compassion with accountability: the difficult conversations

Compassionate leadership is not the avoidance of uncomfortable decisions. A colleague can be under genuine pressure and still need to change behaviour that affects patients or other staff. Failing to address repeated disrespect can be unkind to everyone on the receiving end. The aim is to understand and support the person while being clear about the required standard.

Separate the person, the behaviour and the context

Describe specific observations and their effect rather than labelling someone as difficult or uncaring. "In the meeting yesterday, you interrupted the nurse twice and described her concern as pointless" gives something concrete to discuss. "You are a bully" is a conclusion that may bypass the necessary facts and process. Serious concerns should be managed through the appropriate route, not reduced to an informal coaching exercise.

Invite the colleague's account, examine relevant workload or system factors and agree what must change. Acknowledging context is not the same as excusing conduct. Where appropriate, set review points, record the agreement and follow local performance or conduct procedures. If there is immediate risk, protect patients or staff first; a supportive conversation can follow the urgent action.

Be fair to the whole team

Support should be tailored to need, not limited to people you like or those whose backgrounds resemble your own. Consider whether rota changes, reduced duties or additional support create pressures elsewhere. Explain operational arrangements without disclosing private information. Invite colleagues to raise concerns about workload and make the basis for decisions as transparent as confidentiality permits.

A fair arrangement may not give everybody identical support. The important distinction is between a reasoned response to need and favouritism. Keep opportunities for development, supervision and recognition visible so that compassion is not expressed only when someone reaches a crisis.

WORKED CASE

Supporting a high performer without excusing their conduct

A technically strong colleague has repeatedly spoken sharply to junior staff and says they are exhausted. You first ensure that affected staff are supported and can raise concerns safely. In a private conversation, you acknowledge the workload pressure and explore practical help, but make clear that humiliating colleagues is unacceptable. Agree the immediate behavioural expectations and follow the relevant organisational process where the seriousness or pattern requires it. Review both the workload changes and colleagues' experience. Sympathy for the individual does not remove responsibility for those affected.

When a compassionate decision is unpopular

You may need to decline a request, redistribute work or require a colleague to stop an unsafe activity. Explain the reason and the limits of your discretion. Listen to the impact, explore feasible alternatives and preserve dignity. Do not imply that maintaining a good relationship requires agreement with every request. If trust is damaged, return to the conversation later and check how the working relationship can recover.

Where a colleague rejects support, clarify what remains their responsibility and what assistance is still available. Respect their autonomy within safe professional boundaries. Persistent problems may need formal review. Compassion should influence how that process is conducted; it should not be used to avoid a necessary decision indefinitely.

Make compassion part of routine work

Build brief opportunities to identify pressure into handovers and team meetings. Ensure new starters know how to obtain help. Protect agreed supervision and development time where possible. Examine repeated operational irritants, such as unreliable rotas or duplicate documentation, instead of treating every difficulty as an individual's failure to cope. Recognise helpful conduct and give credit fairly.

Keep your own limits visible too. A leader who takes on every task personally may become another bottleneck and model unsustainable working. Delegate with clear expectations, seek support from peers and managers, and escalate constraints that cannot be safely absorbed. You can take responsibility without pretending to control the whole system.

How to demonstrate this at interview

Prepare one example in which you understood a colleague's difficulty and changed something useful, and one in which you combined support with an unwelcome but necessary expectation. Explain your own role, the effect on others and the follow-up. Avoid claiming that you resolved a complex personal problem or attributing a subsequent improvement entirely to yourself.

For a general question, organise the answer around understanding, action and accountability. The four behaviours can guide your preparation without being spoken as a list. A balanced answer makes clear that you would listen and help, but would also protect patients, support the wider team and review whether anything changed.

ILLUSTRATIVE ANSWER

What does compassionate leadership mean to you?

"For me, it means understanding what makes it difficult for colleagues to do good work, then taking useful action rather than offering sympathy alone. I would listen privately, check the causes of the pressure and agree a practical response, such as clearer priorities, supervision or a change to an inefficient process. I would also consider the impact on the rest of the team and review whether the support worked. Compassion does not remove accountability: if someone's behaviour is harming colleagues or patients, I would address it clearly and fairly while offering appropriate support. My aim is a team that feels respected and is able to deliver reliable care."

How would you know it was working?

Ask colleagues whether they can obtain help, whether concerns lead to action and whether support feels fair. Combine that feedback with relevant operational information, such as repeated missed breaks, late finishes, vacancies, absence or delayed work, interpreted in context. No single indicator proves compassionate leadership. In particular, fewer complaints or incident reports alone may mean that people have become less willing to speak.

Use specific review questions: Did the agreed change happen? Did it reduce the difficulty? Did it shift the burden to somebody else? What still needs escalation? This gives the panel evidence of thoughtful follow-through rather than a claim that you are naturally a caring person.

08

Teamwork, conflict and workplace culture



Build effective working relationships, handle disagreement, create psychological safety and develop a positive team culture.

01 Select a clear example | 02 Reach a workable solution | 03 Maintain or repair trust

8.1 Conflict: constructive disagreement, behaviour and escalation

Conflict is a normal feature of clinical work. It may stem from differences in clinical opinion, resources, workload, communication styles, values or interpersonal behaviour. Panels want to know whether you can distinguish productive challenge from harmful conduct, protect patients and sustain working relationships.

First identify the kind of conflict

A clinical disagreement calls for examination of evidence, patient preferences, relevant guidelines and appropriate senior or multidisciplinary review. A disagreement about resources calls for shared priorities, data and transparent decision-making. Repeated undermining or discrimination may need formal processes and support for affected staff. An immediate patient-safety risk requires prompt action and escalation rather than a leisurely informal conversation.

A consultant-level sequence

Clarify the facts without assuming motives. Consider immediate safety and staff wellbeing. Speak privately and respectfully where appropriate, listening for misunderstandings or pressures. Be clear about expectations and professional standards. Seek a workable agreement with ownership and follow-up. Document and escalate proportionately when conduct persists or risk requires it. Use relevant policies and obtain HR, clinical director, guardian or professional advice when necessary.

IN PRACTICE

An urgent referral disagreement

Two consultants disagree about accepting an urgent referral. The weaker response is “I would tell them the guideline and escalate if they refuse.”

A stronger response clarifies the patient’s risk, listens to the other team’s capacity concerns, seeks a clinically safe interim plan, uses agreed escalation routes if needed and then reviews the pathway so the same dispute does not recur.

Choosing the right conflict example

For many consultant interviews, a non-clinical conflict makes a more effective example than a disagreement over the management of an individual patient. The panel is likely to include people without a clinical background. They need to understand the disagreement quickly, without being drawn into specialist terminology, diagnostic uncertainty or technical details. An example involving rota arrangements, a service

change, teaching, resource allocation, responsibilities or colleagues' behaviour can make the interpersonal and leadership skills much easier to see.

Clinical disagreements can of course be entirely appropriate, particularly if the question specifically asks about clinical conflict. But they are sometimes difficult examples to tell well. The underlying clinical question may require substantial explanation and may raise patient-safety concerns that distract from the point of the answer. The apparent resolution can also be rather uninformative: the team consults the evidence, which might ideally have happened before the dispute became entrenched, or the clinician with ultimate responsibility makes the final decision, ending the immediate disagreement without showing much about how the relationship was managed. Neither is inherently wrong, but neither necessarily demonstrates sophisticated conflict resolution.

When choosing an example, ask yourself what the panel will actually be able to assess. Does the story demonstrate that you were solution-focused: that you clarified the problem, listened, explored options, proposed a workable resolution and followed through? Does it also show that you protected the professional relationship, rather than merely winning the argument? These are two distinct outcomes, and a strong answer should address both.

The relationship may not remain comfortable throughout. There will be occasions when patient safety, professional standards or a necessary organisational decision require you to challenge, overrule or escalate a colleague's position. Do not suggest that good conflict management means avoiding every difficult decision or keeping everyone happy. Explain why the action was necessary and proportionate, how you communicated it respectfully, and what you did afterwards to address any damage to trust. That may include a private follow-up conversation, acknowledging the colleague's concerns, explaining your reasoning, inviting feedback and agreeing how to work together in future.

IN PRACTICE

Changing a rota without losing a colleague

A consultant is implementing a revised clinic rota. A colleague objects strongly because the change affects their established working pattern. The candidate explains the service need and the evidence behind the proposal, listens to the colleague's personal and operational concerns, and adjusts some details without abandoning the essential change. The new arrangement is implemented and reviewed after six weeks.

The strongest part of the answer is not simply that the rota changed: it is that the candidate achieved a necessary outcome while keeping the colleague involved, treating their concerns seriously and preserving the working relationship.

IN PRACTICE

Repairing trust after a difficult decision

A more difficult version: a colleague continues to resist a safety-critical change and the candidate has to make or support a decision against their wishes.

The answer should distinguish the non-negotiable safety requirement from the interpersonal repair that follows. Having the authority to make a decision does not remove the responsibility to explain it, listen and rebuild collaboration.

Practical preparation: identify at least one conflict example outside direct clinical decision-making. Write down the issue in two sentences, your contribution to reaching a solution, what happened to the working relationship and what you did to maintain or repair it. If you also prepare a clinical example, make sure a non-clinical panel member could follow it without specialist knowledge.

Behavioural answers about conflict

Choose an example with genuine tension, not simply a pleasant multidisciplinary meeting. State what you said or did, what you learnt about the other perspective, how you avoided personalising the issue and what happened. Do not portray the colleague as incompetent or malicious. Where confidentiality requires discretion, describe the process and learning rather than naming individuals or revealing private employment information.

The follow-up questions to rehearse

What if the other consultant is senior to you? What if they refuse to engage? What if the disagreement involves your own mistake? What if you are personally upset? What if the team tells you your communication is part of the problem? Good answers adjust to the new risk and demonstrate reflection instead of repeating “I would have a chat”.

8.2 Teamwork, conflict and difficult professional relationships

Disagreement is not automatically a failure of teamwork. Clinical teams contain different expertise, incentives and perspectives; constructive disagreement can improve decisions. The consultant's job is to keep the conversation anchored to patients, evidence, shared goals and professional respect. Avoid portraying yourself as someone who “never has conflict”. More persuasive is an example in which you navigated disagreement and preserved working relationships.

For a behavioural question, use STAR to show how you listened, understood competing positions, clarified expectations, negotiated a workable outcome and reflected afterwards. For a hypothetical situation, explain immediate risks, gather appropriate information, hold a respectful conversation, and consider whether the problem concerns content, a pattern or the relationship. Use formal pathways when necessary, especially with bullying, discrimination or serious misconduct.

What to avoid in answers about colleagues

Avoid assigning motives without evidence, public confrontation, personalising a systems problem, promising complete confidentiality when reporting duties may apply, or describing escalation as punishment. Do not say you would simply “tell HR” or “refer to the GMC” without explaining your own immediate responsibilities. A consultant-level answer balances patient safety, fairness, proportionality and staff wellbeing.

Interview scenario: A senior nurse says your proposed pathway will increase pressure on their team. A strong answer explores the concern, checks workflow and capacity, includes nursing colleagues in the design, considers the patient implications, tests changes and agrees review measures. You do not abandon the proposal automatically, but neither do you treat opposition as disobedience.

8.3 Supporting colleagues and managing performance

A problem with performance can have many causes: unclear expectations, capability gaps, workload, health, personal circumstances, organisational culture or conduct. A consultant should not assume laziness or incompetence. Begin by distinguishing an immediate safety issue from a developmental or employment matter. Deal with urgent safety risks promptly, then gather facts and seek advice through the appropriate clinical, educational or HR route.

Supporting a colleague may include private constructive feedback, supervision, mentoring, access to occupational health, workload adjustments or a clear development plan. More serious or persistent concerns may require documented assessment, designated clinical-management involvement and formal processes. The level of action depends on severity, recurrence and local policy. Do not promise to handle matters alone that require organisational oversight.

A compelling answer makes the dual obligation explicit: patients and colleagues deserve safe care, while the professional concerned deserves fair treatment, dignity and appropriate support. Support and accountability are not opposites.

WORKED CASE

Disagreement with an established consultant

“You join a department where a senior consultant strongly opposes your suggested change to the outpatient pathway. How would you approach this?”

What is being tested: Respect for experience, ability to influence without positional power, evidence-based change, patience and resolve. The panel wants neither a submissive answer (“I would just do what they want”) nor a combative one (“I would tell them it is my service now”).

WORKED CASE

Disagreement with an established consultant

Approach: Begin by clarifying the patient problem and the evidence for change. Seek to understand the colleague's concerns, including unintended clinical consequences and operational dependencies. Meet privately and respectfully where appropriate. Engage other stakeholders, including nursing, administration and patients. Consider a time-limited test rather than insisting on a complete overhaul. Agree what success and failure would look like, and revisit the proposal when data are available. If resistance reveals a genuine safety issue, address it rather than trying to win an argument.

Potential challenge: “What if they still refuse?” Your answer should distinguish ordinary disagreement from obstruction, consider the local decision-making and governance route, and focus on what you can influence without personalising the conflict.

Reflection prompt: Have you ever changed your own proposal because a colleague raised a valid concern? That example may be more persuasive than an account of winning everyone over.

WORKED CASE

Difficult colleagues: support without avoiding accountability

What the panel is testing

This tests whether you protect staff and patients, act fairly, distinguish observation from allegation and can navigate professional relationships without either passivity or premature punishment.

A plausible but weak answer

A weak answer says, “I would have a quiet word and move on,” or “I would refer them to HR immediately.” Both are overly automatic. Neither considers severity, repeated harm, safeguarding, immediate risks or local processes.

A stronger line of reasoning

A stronger approach is: “I would take the concerns seriously, establish what is known, check whether anyone needs immediate protection or support, and avoid prejudging the colleague. I would use appropriate senior or HR advice, follow the organisation’s speaking-up and conduct procedures, and ensure a fair and confidential process. Where appropriate, I would address the behaviour clearly and specify expectations. I would follow up with those affected and check whether conduct and team culture genuinely improve.”

Why this is more convincing

The reasoning combines SPIES with CPR. Patient and staff safety comes before reputational comfort. PEOPLE means dignity and support for both those raising concerns and the colleague involved; RESULT means the harmful conduct stops, not merely that a meeting took place.

The follow-up challenge

“What if the colleague is your clinical director?” The duty to address risk remains. Identify appropriate independent routes, including Freedom to Speak Up and relevant executive or professional leadership. “What if they are having personal difficulties?” Offer support while maintaining safe standards.

8.4 Choose a conflict that reveals how you work with people

For a general conflict question, a non-clinical disagreement is often the clearest choice. A dispute about teaching time, allocation of work, a rota, a shared resource or a service process can be understood by the whole panel. It gives you space to explain listening, negotiation, decision-making and the relationship without spending most of the answer teaching the clinical background.

A clinical disagreement is not automatically a poor example. However, a technical case can be difficult to understand without substantial context, may distract the panel into questions about clinical safety and may end before it reveals much about conflict management. If the difference was resolved simply by consulting a guideline, explain why this had become an interpersonal conflict at all. If the responsible clinician made the final decision, explain what you did to preserve collaboration afterwards. A decision being made is not necessarily a relationship being repaired.

When the question specifically asks about a clinical disagreement or a safety concern, answer that question. Do not substitute a rota dispute to avoid the difficult element. Select an appropriate real example, use plain language and preserve confidentiality. The advice to favour non-clinical material is about clarity and evidential value, not concealment.

Prepare the two outcomes

The first outcome is a workable solution to the substantive problem. The second is a professional relationship that remains functional. They are related but not identical. A compromise may preserve goodwill while leaving the problem unresolved. An imposed solution may resolve the immediate problem while damaging trust. Your answer should explain both outcomes honestly.

Describe what each person needed, not just what they demanded. A colleague asking for protected time may be concerned about fairness, a professional obligation or a long-standing imbalance. Ask what makes the issue difficult for them. You do not have to agree with their proposed solution in order to recognise a legitimate concern.

Explain the conversation, not just its existence

"I spoke to them privately" is a setting, not a conflict-management method. What did you say? How did you invite their account? What did you discover? What did you acknowledge about your own contribution? What options did you explore, and how was the decision reached? Those details reveal the skills the panel is trying to assess.

Avoid presenting yourself as the only reasonable person. A useful account can include a point on which the other person was right or an assumption you had to revise. This strengthens the example when it demonstrates genuine insight rather than an invented display of humility.

When agreement is impossible

Not all conflicts can be settled by mutual agreement. Where a decision is yours to make, explain the rationale, boundaries and route for review. Where it is not, use the appropriate senior or organisational process. Escalation is not a threat or a way of winning; it may be the legitimate route to resolve a matter beyond your authority.

Immediate safety action should not be delayed to protect a relationship. Equally, urgency does not justify avoidable humiliation. Act proportionately, describe the concern factually and return to the interpersonal consequences when the immediate issue is controlled.

IN PRACTICE

A necessary decision strains the relationship

A service lead stops an agreed activity because the required support is unavailable. A colleague feels publicly overruled. The lead first makes the immediate arrangement safe, then meets the colleague privately. They explain the reason for the decision, acknowledge that the way it was communicated caused embarrassment and ask how the situation appeared from the colleague's perspective.

They agree clearer escalation and communication arrangements for future changes. The lead does not withdraw a justified safety decision merely to restore goodwill, and does not pretend the conversation immediately erased the tension. At review, they check whether collaboration has improved.

Show repair through subsequent behaviour

Relationship repair may involve an apology, acknowledgement of an impact, clearer expectations, a different communication process or a facilitated conversation. It is not enough to say "we shook hands". Explain whether you continued to work together, whether the agreed process was used and what you would do if the difficulty persisted.

A good closing reflection can be: "I learned to separate disagreement about the decision from how the person experienced the process. I could maintain the necessary boundary while improving the way I involved and communicated with them." Use your own evidence; do not adopt a polished conclusion that the event does not support.

8.5 Support and accountability in a difficult colleague scenario

Begin with observable behaviour and its effect. "The colleague is difficult" is a judgement; repeated interruptions, missed commitments or dismissive comments are behaviours that can be explored. Check the

information, consider immediate risk and avoid building a case from rumour. Where there is a safety concern, act through the proper route rather than conducting your own informal investigation.

In a private conversation, explain the concern clearly, invite the colleague's account and remain open to factors you do not yet know. Workload, ill health, unfamiliar systems, lack of training or personal difficulties may be relevant. Do not diagnose them or assume that an explanation removes the need for standards. Agree what must change, what support is appropriate, who is responsible and when progress will be reviewed.

If the behaviour is serious, repeated or outside your authority to manage, involve the relevant clinical lead, manager or other appropriate service. Bullying, discrimination and safeguarding concerns may require formal action; mediation is not a universal substitute for that action. Protect those raising concerns, explain the limits of confidentiality and follow local policies.

In interview answers, avoid two extremes: promising to sort everything out alone, or immediately transferring the problem to HR without making any clinical or leadership judgement. Explain what you can responsibly do yourself and where additional authority, expertise or process is needed.

PUT IT INTO PRACTICE

Prepare both conflict outcomes

Select a clear, preferably non-clinical example for a general conflict question. Record the solution and the subsequent working relationship separately.

Self-check: What did you do if a justified decision made the relationship worse?

8.6 Creating psychological safety in your unit

Psychological safety is the shared confidence that people can ask questions, admit uncertainty, acknowledge an error or challenge a plan without being humiliated or unfairly penalised. The practical test is not whether people describe the department as friendly. It is what happens when a student, nurse, administrator, locally employed doctor or senior colleague says something that the consultant would rather not hear.

A consultant influences this through everyday behaviour, especially under pressure. An open-door statement or an annual survey cannot substitute for the experience of being listened to. At interview, explain what you would do, how you would respond to a difficult moment and how you would establish whether less powerful members of the team felt able to contribute.

High standards and psychological safety belong together

Psychological safety does not mean that every suggestion is adopted, decisions require unanimity, poor performance is ignored or all conduct is free from consequences. It makes honest discussion possible so that standards can be maintained. Distinguish an understandable error or a system problem from repeated unsafe behaviour, bullying, dishonesty or deliberate disregard of safeguards. Investigate fairly and use the appropriate process rather than promising automatic punishment or unconditional immunity.

Nor is psychological safety a description of an individual's mental health. A highly capable person may be reluctant to speak within a particular hierarchy. A confident senior colleague may feel safe in a unit where others do not. Assess the experience of different groups rather than assuming your own experience represents the team.

Understand whose voice is missing

During induction and early conversations, ask how concerns are raised, which discussions are difficult and what happened the last time someone challenged a senior decision. Speak with different professions, grades and employment groups. Include night staff, locums, international recruits, students and colleagues who do not attend the main departmental meeting. Ask for examples rather than inviting people to label the department as good or bad.

Bring together staff feedback, training surveys, exit themes, complaints, incident narratives and observations of meetings. Low reporting is ambiguous: it may reflect fewer problems, poor access or fear of repercussions. Explain confidentiality limits before sensitive conversations. Do not promise anonymity that you cannot protect or publish small-group data that could identify individuals.

Make your own fallibility visible

Explain what you know, what is uncertain and where another professional may have better information. "I may have missed something - what concerns you about this plan?" invites scrutiny without surrendering clinical

responsibility. Acknowledge mistakes promptly and explain the learning. Avoid performative self-criticism or transferring responsibility for your emotions to the team.

Where appropriate, invite views before announcing your preferred solution. Once the senior person gives a strong opinion, disagreement may become harder. Explain the eventual decision, including which concerns changed it and why other suggestions could not be adopted. Listening does not remove the need to make a timely decision.

Build predictable opportunities to contribute

Use briefings, safety huddles, multidisciplinary meetings and debriefs with a clear purpose. Introduce people and clarify roles. Ask specific questions: "What is most likely to go wrong today?", "Who is carrying an unmanageable workload?" and "What would make this handover safer?" Invite perspectives across professions without placing an unprepared junior colleague on the spot.

Offer more than one route: a conversation during the shift, a private discussion afterwards and established escalation or speaking-up channels. Some concerns cannot wait for a meeting. Agree how urgent concerns should interrupt work, who takes responsibility and what colleagues should do if the first response is inadequate. A suggestion box is not an emergency escalation system.

Your first response to challenge sets the tone

Stop, listen and thank the person for raising the concern. Clarify the facts and consider immediate risk. Separate the validity of the concern from the way it was expressed: an awkwardly worded warning can still be important. Explain the next step and who will act. If a concern is not substantiated, explain why respectfully rather than suggesting that the person should have remained silent.

Sighing, sarcasm, public interrogation or jokes at someone's expense can suppress future contributions even when no formal sanction follows. If your reaction was poor, return to it explicitly. Acknowledge the behaviour, apologise appropriately and explain what you will do differently. "I was busy" may explain pressure but does not excuse humiliation.

IN PRACTICE

The warning that interrupts a busy list

A new team member questions whether an essential check has been completed. The consultant believes it has and is under time pressure. "We have already dealt with that" may end the conversation without establishing whether the check is reliable.

A stronger response is to pause, thank the colleague, verify the position and resolve any risk. Afterwards, explain what happened and reinforce that the interruption was appropriate. If the concern was mistaken, correct it without humiliation. The aim is to make challenge usable, not automatically agree with it.

Close the loop and prevent retaliation

Tell the person what was done, what remains unresolved and when an update can be expected, within confidentiality limits. Acknowledge when an issue cannot be resolved within the department and show how it has been escalated. Record agreed actions proportionately and revisit them. Repeatedly asking for feedback without visible follow-through can increase cynicism.

Watch for less visible consequences after someone speaks up: exclusion from meetings, reduced training opportunities, hostile comments or inconvenient allocations of work. Address patterns rather than assuming silence means the person feels safe. Involve management, HR, educational or speaking-up support as appropriate. Do not conduct an investigation alone when independent oversight is required.

Make learning conversations fair and useful

After an event, distinguish the immediate clinical response, support for those affected, formal reporting and the learning conversation. Explore the information people had, why actions seemed reasonable at the time and which conditions increased risk. Include what worked well. A debrief does not replace a required investigation or open communication with patients and families.

Agree specific improvements with owners and review dates. Test whether a change improves work rather than merely adding another form. Describe behaviour and impact in feedback: "The colleague was interrupted three times" opens a more useful conversation than "You are not a team player". Challenge conduct fairly without turning an understandable systems error into a character judgement.

Check whether the experience has changed

Review whether different professions contribute in meetings, whether concerns receive a timely response and whether actions are completed and tested. Combine confidential staff feedback with examples, rather than relying on a single survey score. Examine variation by grade, profession and working pattern while protecting confidentiality.

Do not use fewer reports as a stand-alone target. Reporting may increase when trust improves. Conversely, more reports do not automatically demonstrate a healthier culture. Ask what the reports contain, whether repeat problems are being addressed and whether people understand what happens after they raise a concern.

ILLUSTRATIVE ANSWER

How would you create psychological safety?

"I would first understand whose voice is missing, including colleagues outside the main daytime team. I would make it clear that raising uncertainty and challenging a plan are professional contributions, and model this by inviting views before giving my own where possible.

"I would use briefings and debriefs to make participation routine, with routes for urgent concerns and private follow-up. The key test is my response when challenged: listening, assessing risk, explaining the decision and closing the loop. I would address humiliating behaviour and retaliation rather than leaving the individual to deal with them alone.

"I would assess staff experience across grades and professions alongside evidence that concerns lead to action. Psychological safety should help the team maintain standards, not avoid difficult conversations."

8.7 Developing a positive workplace culture

Culture is the pattern of behaviour people come to expect: how decisions are made, whose contribution counts, what is praised, what is tolerated and what happens under pressure. A department may display excellent values while rewarding speed at any cost, protecting a difficult high performer or relying on quieter colleagues to absorb extra work. Those choices reveal its culture more clearly than its posters.

Psychological safety is one part of a positive culture. The broader task includes shared purpose, reliable teamwork, fair treatment, development, manageable work, accountability and pride in good care. Friendliness is welcome but does not make an inequitable or unsafe service healthy. A consultant should connect the team's experience with the quality and sustainability of its work.

Understand before announcing a culture change

Ask colleagues across the service what helps them do good work, what repeatedly gets in the way, what they are proud of and what they would change. Observe handovers, meetings and everyday interactions. Look for differences between sites, shifts and professional groups. Include patient and carer feedback. Avoid arriving with a diagnosis that the department needs to be rescued.

Identify strengths to preserve and a few behaviours to improve. A team exhausted by reorganisations may not welcome another large initiative. Choose an issue that matters, define it clearly and make the first improvement visible. Leadership includes removing obstacles, not simply asking people for more effort.

Translate values into working agreements

Agree what the trust's values mean in this unit. Respect may mean not interrupting or criticising colleagues publicly. Accountability may mean an owner and deadline for each decision. Collaboration may mean involving the receiving team before changing a referral pathway. Develop a short, usable agreement and apply it to consultants as well as trainees and other staff.

Explain how disagreement should be handled. Challenge ideas without attacking individuals. "That is just how they are" is not an adequate response to intimidation or discriminatory behaviour. Set expectations early, intervene proportionately and use formal processes where severity or repetition requires them.

Role-model behaviour when it is difficult

Arrive prepared, keep commitments, acknowledge other professions' expertise and share credit accurately. Discuss an operational problem with the other team rather than sending blame-laden messages. When you cannot deliver, explain the constraint early and negotiate a realistic alternative. People learn from your response to a delayed clinic, not only from your contribution to an away day.

Make accountability reciprocal. Invite feedback on your own leadership and demonstrate a resulting change. Apologise for abrupt behaviour without using workload as an excuse. This does not mean reversing a necessary decision; it means taking responsibility for the manner in which it was communicated.

Improve the conditions in which people work

Distinguish a motivation problem from a work-design problem. Unreliable equipment, unclear responsibilities, last-minute rota changes, poor induction and interruptions can defeat a committed team. Work with nursing, allied health, administrative and operational colleagues to identify avoidable friction. Agree ownership and escalate constraints beyond the unit's authority.

Discuss job planning, supervision, development and workload realistically. Encourage breaks and support, but do not offer resilience training as the sole response to an unsafe workload. Be clear when resources are insufficient and prioritisation is needed. A positive culture includes honesty about what cannot safely be delivered.

Build relationships across professional boundaries

Use shared objectives and practical joint work rather than assuming everyone understands everyone else's pressures. Invite people affected by a proposal to help design it. Clarify responsibility at interfaces, including ownership of results, referrals and follow-up. Treat administrators and support workers as contributors to reliable care, not an audience for decisions already made.

When colleagues disagree, explore the work behind their positions. A nurse's objection to a clinic may reflect staffing; a manager's response may reflect a genuine constraint or missing information. CPR helps: consider a different approach, support the people affected and agree the result sought. A workable compromise should not disguise an unresolved safety problem.

Recognise contribution and develop others fairly

Recognise useful work specifically: a thoughtful handover, less duplication, support for a colleague or a well-managed difficult conversation. Avoid celebrating only heroic effort. Repeatedly staying late should prompt questions about workload as well as appreciation. Make less visible contributions visible and share credit across the team.

Advertise projects and teaching opportunities rather than allocating everything to familiar colleagues. Agree stretch tasks with support, feedback and recognition. Coaching helps someone develop their own solution; mentoring helps them draw on experience and navigate choices. Neither should be reserved for colleagues who already appear confident.

Address poor conduct, including among high performers

When behaviour affects dignity, teamwork or safety, describe what happened and its impact, listen and agree expectations and follow-up. An isolated lapse may allow an informal conversation. Serious allegations, discrimination, harassment, retaliation or a persistent pattern may require formal action. Do not force mediation on someone reporting serious misconduct or a substantial power imbalance.

Apply standards consistently. Protecting an individual because they generate activity or have a prestigious reputation tells others that some people are exempt. Equally, avoid publicly labelling a colleague or prejudging an allegation. Support those affected, protect safety and involve appropriate organisational expertise.

IN PRACTICE

The respected colleague whom everyone avoids

A technically respected consultant regularly humiliates staff during handover. Others say the service cannot afford to upset them. Junior staff increasingly avoid asking questions.

A constructive response does not trade dignity for productivity. Clarify the behaviour and risk, support affected colleagues and raise concerns through appropriate leadership and employment processes. Agree how improvement will be evaluated. The individual's technical contribution remains recognised but does not remove accountability.

Develop a realistic first-90-days plan

In the first month, listen across grades, professions and shifts; understand existing strengths, concerns and available measures. Agree two or three priorities rather than a long list of promises. In the second month, co-

design working agreements, remove a recurring obstacle and clarify escalation and development opportunities. Name owners and realistic deadlines.

In the third month, review experience and results, address unintended effects and embed useful changes in induction and team routines. Explain to colleagues what changed, what remains unresolved and why. This is an illustrative sequence, not a rule that urgent safety concerns should wait for a scheduled review.

Measure behaviour and experience, not just sentiment

Combine staff feedback with examples of behaviour and delivery. Review retention, sickness themes, training access, incidents, complaints and reliability of team processes without assuming one measure explains culture. Differences between groups may matter more than an average. Protect confidentiality and examine who does not respond to feedback requests.

A useful outcome is not simply that a workshop occurred. It is that people know what is expected, concerns receive fair responses and work is organised more reliably. Revisit agreements when staff rotate, leadership changes or pressure exposes weaknesses. Sustaining culture requires routines and accountability, not permanent dependence on one enthusiastic consultant.

INTERVIEW APPLICATION

Show what you changed in everyday work

Choose an example that demonstrates more than organising a social event. Explain the working problem, how you involved colleagues, the behaviour or process that changed and the evidence of improvement.

For a hypothetical answer, use four connected headings: shared purpose and standards; working relationships; practical working conditions; and follow-through. Link wellbeing to workload, inclusion to opportunity and accountability to fair support.

09
Mistakes, dilemmas and professional judgement



Use SPIES intelligently, discuss mistakes with insight and balance support, safety and accountability.

01 Use SPIES intelligently | 02 Discuss mistakes honestly | 03 Act within professional duties

S	P	I	E	S
Seek information	**Patient safety**	**Initiative**	**Escalation**	**Support**
Establish reliable facts.	Act on immediate risk.	Act within your role.	Obtain the right support.	Care for those affected.

9.1 SPIES: responding to an unsafe or difficult situation

SPIES is a practical checklist for difficult colleague and safety scenarios: Seek information, Patient safety, Initiative, Escalate, Support. Its value lies in preventing omissions while leaving room for judgement. It must not be treated as a fixed sequence when immediate action is required.

Element	Consultant-level questions to ask yourself
S — Seek information	What do I know, what is alleged, what is unclear, and who may be affected?
P — Patient safety	Is there an immediate risk requiring protective action now?
I — Initiative	What can I appropriately do: discuss, supervise, arrange cover, record, solve a system issue?
E — Escalate	Who has the authority or responsibility to help, and how urgently?
S — Support	How do I support patients, the colleague, those reporting concerns and the wider team?

Example scenario: A consultant colleague appears impaired at work. Protect patients immediately, arrange safe clinical cover and involve appropriate senior leadership under local policy. Establish facts without turning an urgent risk into a lengthy private investigation. Maintain confidentiality, document objectively, escalate appropriately and ensure the colleague can access support. A mature answer combines decisive safety action with fairness and compassion; it neither ignores the risk nor assumes guilt without evidence.

For bullying, discrimination, repeated lateness or concerns about underperformance, the balance of inquiry, direct action, formal processes and support will vary. Explain your principles before listing every possible step, and refer to GMC duties and organisational policy.

SPIES is a safety and professionalism checklist

SPIES stands for Seek information, Patient safety, Initiative, Escalate and Support. It is particularly helpful when the panel presents a difficult colleague, professionalism or safety scenario that can tempt a candidate into either immediate confrontation or passive avoidance. Its role is to ensure you consider the facts, the risks, the action within your responsibility, the need for appropriate senior or organisational involvement and the human support required. The order is not rigid. If a patient faces imminent risk, protecting safety comes first; a long fact-finding discussion would be inappropriate.

Seek information means establish what you know and do not know without gossip or assumptions. Patient safety means consider both immediate harm and wider risk. Initiative means take proportionate action yourself: you should not outsource every difficult conversation to HR or the medical director. Escalate means use the appropriate structure when risk, seriousness, repetition or authority requires it. Support means protect patients and offer appropriate help to colleagues and teams, including those affected by a concern. Respect confidentiality, documentation and local procedures throughout.

Worked scenario: a colleague repeatedly undermines a junior doctor

You hear that a consultant repeatedly criticises a junior doctor in front of patients. First establish credible information and assess immediate consequences for patient care and the junior's wellbeing. Speak privately and respectfully to the affected trainee, listen and explain options for support and speaking up; do not promise secrecy you cannot maintain. Depending on what is known, it may be appropriate to address observed conduct directly and make clear the standards expected. Repeated, serious or discriminatory behaviour may require formal escalation to appropriate clinical, educational or employment leads under local policy. Check that the trainee is safe, that potential repercussions are monitored and that follow-up occurs. A convincing answer distinguishes a one-off misunderstanding from an established pattern and balances fairness with the duty to act.

Typical errors in difficult-situation questions

Candidates sometimes assume guilt too early, minimise poor behaviour because the colleague is senior, jump straight to a disciplinary process, or confuse patient safety investigation with employment processes. Others say only, “I would escalate,” which may show avoidance of their own responsibility. The panel is looking for practical judgement: urgency, evidence, proportionality, compassion, accountability and follow-through. Show what changes your approach when a risk is immediate, a concern is repeated or professional support is needed.

9.2 Discussing a clinical mistake safely and convincingly

Questions about clinical mistakes and professional setbacks can be some of the most revealing in a consultant interview. The purpose is not to obtain a dramatic confession. It is to understand honesty, insight, patient-centred action, responsibility and learning. The panel is assessing how you behave when your judgement or practice falls short.

What to choose

Choose a true, sufficiently resolved example that you can discuss accurately and proportionately, ideally one in which you personally had a clear role and there is genuine learning. A delayed recognition of a problem, an incomplete handover, a missed opportunity to escalate, an overcomplicated pathway or an imperfect communication decision may be appropriate if the details are suitable for professional discussion. The best example is not necessarily the one with the greatest harm.

What to cover

Briefly describe the clinical context and your role. Say what went wrong and what you personally missed or did. Describe the action taken to protect the patient, involve appropriate seniors or colleagues, communicate openly with the patient where applicable, make accurate records and follow the relevant reporting and duty-of-candour requirements. Explain the learning process and changes made to practice or systems, then what evidence suggests those changes helped. Be honest about uncertainty and avoid pretending that risk has been eliminated.

What not to say

Do not include identifiable patient details, colleagues' confidential information, or unnecessary facts about ongoing investigations or legal proceedings. Do not breach a confidentiality obligation or misrepresent what occurred. Do not blame a trainee, nurse or system to avoid your own responsibility; equally, do not take personal responsibility for actions you did not perform. Avoid "nothing bad happened, so it was fine", "I have never made a mistake", or "I now triple-check everything" as the sole learning.

IN PRACTICE

Learning from a missed result

A candidate describes overlooking an abnormal result during a busy handover. They explain how they recognised and escalated the problem, ensured follow-up and appropriate communication, reported it through the organisation's process and helped improve the results-handling system.

The learning is not just "I am more careful"; it addresses handover reliability, ownership and safeguards.

Important professional boundary

Interview preparation is not a substitute for meeting professional duties. If an incident remains unresolved or triggers reporting, candour, regulatory or employer obligations, fulfil those obligations regardless of interview strategy. Seek appropriate advice where confidentiality or a current investigation limits what you can discuss. The GMC's Good medical practice and accompanying candour guidance should inform your approach.

INTERVIEW INSIGHT

The strongest mistake answer is neither a confession designed to shock nor a polished story with no uncertainty. It is a proportionate account of responsible action and credible learning.

9.3 The consultant as a professional and organisational citizen

Current GMC Good medical practice emphasises four broad domains: knowledge, skills and development; patients, partnership and communication; colleagues, culture and safety; and trust and professionalism. The 2024 version gives a prominent place to respectful and fair working cultures, raising concerns, supporting colleagues and collaborative care. These are highly relevant to questions about leadership, values, difficult colleagues and professionalism.

The public expects consultants to be clinically capable, but also truthful, accessible, fair and accountable. A senior doctor helps shape the everyday behaviour of a department: whether trainees can challenge decisions, whether nurses are heard, whether concerns reach leaders and whether mistakes lead to improvement. An excellent interview answer reflects that responsibility.

Professional dilemmas

For a scenario involving consent, confidentiality, conflict of interest, conduct or patient safety, identify the underlying professional duty; acknowledge uncertainty and the facts needed; act to protect patients and respect rights; use appropriate advice and governance; and explain how you would document and learn. Refer to the GMC's current Decision making and consent guidance for supported patient choices. Do not rely on an outdated quotation of a paragraph number from the pre-2024 GMC guidance.

WORKED CASE

Possible impairment of a colleague at work

What is being tested: Immediate protection of patients, decisiveness, fairness, confidentiality and escalation. SPIES is a useful mental checklist, but safety must not wait while every letter is addressed sequentially.

Approach: If there is an immediate concern about fitness to practise, act promptly to protect patients, ensure safe cover and involve the appropriate clinical or managerial authority. Establish what has been observed and avoid spreading speculation. Follow local policies on fitness for work, raising concerns and documentation. Consider whether patients already seen need review, depending on the nature and extent of the risk. Support the colleague respectfully and ensure access to appropriate professional and health support. Do not promise secrecy where patient safety may require formal action.

WORKED CASE

Possible impairment of a colleague at work

Potential challenge: “What if this consultant is your close friend or the clinical director?” Personal relationships do not override patient safety or reporting obligations. If a normal escalation route presents a conflict, identify another appropriate route, such as medical director-level advice or speaking-up arrangements.

Common pitfall: Suggesting that you would quietly send a clearly impaired colleague home without making arrangements for the patients affected or informing appropriate leadership.

9.4 Use SPIES as a prioritisation tool, not a timetable

SPIES stands for Seek information, Patient safety, Initiative, Escalation and Support. Its sequence should not delay urgent action. If a patient is immediately at risk, protective action may occur while you clarify the facts. In a less urgent concern, a careful conversation may be the right starting point. Explain why the order fits the situation.

Seeking information means establishing enough reliable detail to act appropriately. It does not mean interrogating everyone involved before addressing an obvious hazard. Clarify what is known, what is reported and what is uncertain. Consider who has the appropriate responsibility and whether other patients or staff may be affected.

Initiative means doing what is within your competence and authority. It does not mean bypassing a safety system or personally conducting a formal investigation. Escalation should name the purpose: to secure senior clinical support, appropriate staffing, a management decision or a formal review. "I would escalate" is incomplete without explaining what help is needed and how you would confirm action.

Support belongs throughout the answer. Patients and families may need information, care and a named contact. Staff may need supervision, practical support and access to appropriate services. The person raising a concern may need assurance about the process and protection from retaliation. Support does not mean promising secrecy that you cannot maintain.

Explain a clinical mistake without turning it into a clinical examination

Choose an authentic example that you can discuss proportionately. Establish the relevant risk, your role, what you missed or did and how the problem was recognised. Give enough clinical context to understand why the error mattered, but avoid a detailed technical debate unless the panel asks for it. A mixed panel needs to understand your judgement and response.

Move quickly to immediate care, communication, reporting, review and learning. Be explicit about what you personally did, what others did and what remains uncertain. Do not claim that a favourable outcome proves the mistake was unimportant. Near misses can reveal serious weaknesses even where harm was avoided.

Give learning a practical form

"I am more careful" is an intention. A stronger reflection explains the conditions that made the mistake possible and the change that followed. This might include a clearer ownership rule, a reliable handover, an escalation trigger or a change to how work is checked. Explain how you know the change is used, and acknowledge residual risk.

Personal and system learning can coexist. You can recognise that you missed an opportunity to clarify a plan while also recognising a defective handover process. Do not use a system explanation to disappear from your own story, or take responsibility for every feature of a complex service.

IN PRACTICE

A mistake with a limited but honest outcome

A candidate describes failing to confirm who would follow up a test result. When the omission is recognised, they ensure the patient is reviewed through the appropriate clinical route and support open communication and reporting. The team clarifies responsibility in the handover process.

At interview, the candidate does not say the new process eliminated all risk. They explain that a subsequent review found better documentation of ownership, while acknowledging that documentation alone does not prove every result was acted on. This makes the learning credible rather than artificially complete.

Do not let interview strategy override professional duties

Keep identifying information out of your answer and avoid details that could identify a patient indirectly. Meet any required candour, reporting, regulatory or employer obligations independently of how you prepare for an interview. Where a matter is ongoing or legally sensitive, obtain appropriate professional advice about what can be discussed and what must be disclosed. Choosing a suitable example is not permission to conceal a matter you are required to report.

If asked a direct question, answer honestly within the relevant confidentiality and professional boundaries. A simple statement that you cannot discuss identifying or legally restricted details is better than inventing an uncomplicated account. You can still explain your responsibilities and the learning that you are able to discuss.

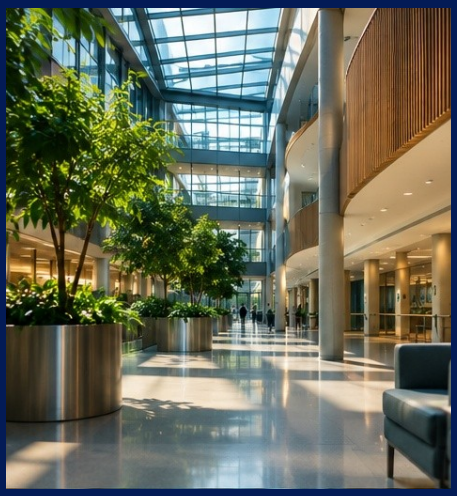
PUT IT INTO PRACTICE

Test the safety and reflection

Choose a suitable mistake example and remove unnecessary identifying or technical detail. Explain care, communication, reporting, learning and follow-through.

Self-check: Have you made your responsibility clear without claiming knowledge or outcomes you do not have?

10 Improvement, change and your first 100 days



Move from a good idea to a tested, measurable and sustainable improvement in a real service.

01 Define the problem	02 Test and evaluate change	03 Sustain the improvement

10.1 Service improvement and change management

Panels often ask how you would develop a service because the question reveals whether you understand the realities beyond your own clinical practice. Avoid offering a grand solution before you understand local demand, outcomes, workforce, resources, patient experience and the current pathway. The most credible candidates propose an approach to improvement, not a shopping list of ambitions.

Use five stages. Diagnose the problem with data and front-line insight. Prioritise using safety, patient benefit, feasibility and strategic fit. Engage staff, patients and partner services early. Test and implement a proportionate change with clear responsibilities. Evaluate and sustain the improvement, including unintended consequences. Describe how you would use iterative methods such as PDSA cycles when suitable, while recognising that some problems require formal redesign and business approval.

Measures that matter

A good improvement plan uses more than activity counts. Consider outcome measures (what patients experience or achieve), process measures (whether the intended change is happening) and balancing measures (whether improvements create new problems elsewhere). For access projects, measure time to appointment and clinical outcomes, but also staff workload, demand shifts, equity and patient feedback. Separate productivity from simply asking staff to work harder.

Example question: “How would you reduce our outpatient waiting list?” A thoughtful response begins by understanding demand, referral quality, clinical urgency, capacity and variation. It may include triage review, reducing avoidable follow-ups, shared care, workforce redesign or digital support, but it must safeguard clinical outcomes, inequalities and sustainability. Invite patient and staff perspectives before presenting a preferred pathway.

10.2 Audit, quality improvement and evidence of impact

Clinical audit measures practice against explicit standards and supports change where performance falls short. Quality improvement uses systematic methods to understand a problem, test changes and improve outcomes over time. They overlap but are not interchangeable; an audit without action or re-measurement may offer limited assurance of improvement, while an improvement project needs reliable data to show whether the change worked.

Be ready to explain your project in ordinary language: the problem, baseline, aim, standard or measure, intervention, stakeholder involvement, results, sustainability and learning. Interviewers may probe attribution: “How do you know the improvement was due to your intervention?” Honest limitations strengthen rather than weaken your credibility. Be prepared to discuss sample size, variation, confounders and unintended consequences at a level proportionate to your involvement.

A project narrative that stands up to questions

“I noticed X problem affecting Y group. We used Z information to understand the scale. I led/participated in A, with B colleagues. We tested C, measured D and observed E. Our main limitation was F; we therefore changed G / plan to re-audit at H.” This is a narrative template, not a claim that every project must contain all of these elements.

10.3 A consultant's first 100 days

A 100-day plan shows realism if it is used as a guide rather than an inflexible promise. In the first month, your emphasis is on listening and understanding: relationships, safety, pathways, responsibilities, objectives and unwritten dependencies. In the next phase, you can prioritise and build alliances, identifying a small number of realistic improvements. Later, begin delivery and review, with agreed measures and transparent communication.

Period	Priorities	Evidence of sensible progress
Days 1–30	Meet key stakeholders; learn service and governance processes; review local data and job plan	Shared understanding of priorities, risks and relationships
Days 31–60	Agree feasible goals; involve colleagues and patients; clarify support and resources	Prioritised workplan with named collaborators and measures
Days 61–100	Begin targeted improvement; review learning; refine approach	Visible early progress without exaggerated promises

The plan should reflect the actual post. A newly appointed consultant may need to consolidate a clinical practice and participate in the existing team before leading major change. The panel will usually value judgement over an ambitious pledge that cannot be delivered.

WORKED CASE

Leadership under pressure: CPR in a real service decision

“You arrive in a department with long outpatient waits. What would you do in your first six months?”

What the panel is testing

The panel is not seeking an instant operational miracle. It is assessing whether you can diagnose problems, work with colleagues, set realistic priorities, deliver change and avoid making unsafe assumptions.

A plausible but weak answer

A weak response would announce additional clinics, stricter targets and a new pathway before understanding demand, capacity or case mix. It sounds energetic but can imply that staff are the cause of the problem or that more activity automatically means better access.

A stronger line of reasoning

A stronger response starts with evidence: “I would first work with clinical, nursing, administrative and operational colleagues to understand the referral mix, waiting-list validation, available appointments, follow-up demand, variation and any safety risks. We would identify which patients need earlier review and which steps add delay without benefit. I would agree one or two changes with the team, test them on a manageable scale, and review waiting times alongside quality, staff workload and patient experience.”

Why this is more convincing

CHANGE is visible in examining assumptions and trialling a redesigned process. PEOPLE is visible in engaging those who deliver and use the service, including colleagues who question the proposal. RESULT is visible in explicit measures, ownership and review. Notice that the answer does not overpromise an arbitrary percentage improvement.

WORKED CASE

Leadership under pressure: CPR in a real service decision

The follow-up challenge

“What if senior colleagues refuse to change?” Explore their concerns and evidence, distinguish legitimate risk from habit, and use a co-designed test rather than managerial pressure alone. “What if performance improves but complaints rise?” Reassess safety, equity and experience: that is not an unqualified success.

10.4 Design an improvement that survives contact with the service

Start with the problem, not the preferred intervention. "We need a new clinic" is a proposed solution. The underlying problem might be delayed decisions, duplicated review, poor access to advice or lack of diagnostic capacity. Different problems require different interventions. Define who is affected, what currently happens and why the issue matters to patients and staff.

Agree an aim that is specific enough to evaluate and realistic enough to test. Establish the baseline, the population included and the timescale. Do not borrow an impressive target from another service without understanding its case mix, resources or starting point. A useful early aim may be to establish a reliable process before promising a dramatic change in outcomes.

Understand the pathway before changing it

Map the work as it happens, including handovers, exceptions, rework and delays. Ask the people doing the work where the process becomes difficult. Include administrative and support staff as well as clinicians. A step that looks unnecessary from one position may be an important safeguard from another.

Consider the whole pathway. Reducing the time in one clinic is not an improvement if the work reappears as extra phone calls, avoidable emergency attendances or an unmanageable burden in primary care. Identify who gains, who takes on extra work and who may find the new process harder to access.

Test on a scale that can teach you something

A pilot should have a purpose, an owner, a defined scope, measures and a review point. It should not become permanent merely because nobody arranged to stop it. Agree what would justify expansion, modification or withdrawal. Where safety, information governance, commissioning or other approvals are required, a small scale does not remove those requirements.

Describe adaptation rather than a perfect first design. For example, a referral form may reduce omissions but be too long for urgent use. A pilot can reveal this before wider implementation. The ability to incorporate unwelcome feedback is a strength, not an admission that the project was poorly conceived.

Measure benefit and unintended effects

An outcome measure asks whether the intended benefit occurred. A process measure asks whether the intended change was carried out. A balancing measure asks whether another important aspect became worse. For a referral redesign, these might concern timely review, completeness of information and administrative burden. Choose measures that can inform a decision, not a dashboard full of numbers that nobody uses.

Before-and-after comparisons need cautious interpretation. Changes in demand, case mix, staffing or data recording may influence the result. Explain what your evidence supports and what it does not. When formal evaluation was limited, say so and explain what you would improve next time.

IN PRACTICE

The apparent improvement that moved the work

A service reduces booked follow-up appointments. The headline activity looks more efficient, but nurses receive more calls from uncertain patients and GPs report unclear responsibility for monitoring. A candidate who looks only at the outpatient figure celebrates too early.

A stronger account explains how the team reviews patient understanding, advice access and work transferred to others. The service may still be able to reduce unnecessary appointments, but the supporting process needs redesign. The lesson is to measure the pathway rather than the convenience of one department.

Make sustainability an explicit workstream

Decide who owns the process after the project lead leaves. Put essential instructions into ordinary systems, not only a presentation. Include induction for new staff, access to support, a manageable review mechanism and a response when performance deteriorates. Where the change depends on extra time or resource, make that dependency visible.

In an interview, sustainability provides evidence of leadership beyond launch. Explain how you supported successors and what you did to avoid becoming indispensable. A project that functions only because you chase every case may demonstrate commitment, but not yet a reliable service model.

Translate the approach into your first 100 days

Treat the first 100 days as a planning device, not a contractual promise. In the early phase, understand people, governance, pathways and baseline performance. Then agree a small number of priorities with those responsible. Test feasible improvements and establish how progress will be reviewed. Immediate safety concerns still require prompt action; listening is not a reason to postpone necessary intervention.

Do not promise to redesign an entire department before you know its constraints. A credible first-year contribution is often a combination of reliable clinical practice, good relationships, one agreed improvement and clear professional development. Explain how this fits the job plan and existing priorities rather than adding an unlimited list of new responsibilities.

10.5 A consultant-level improvement brief

Question	What a useful answer contains
What problem are we solving?	Patient or service need, baseline evidence and who is affected.
What are the options?	Including a reasonable alternative and the consequences of doing nothing.
Who must be involved?	Patients, the multidisciplinary team, managers and relevant pathway partners.
What could go wrong?	Safety, access, workload, equity, data and resource dependencies.
How will we test it?	Scope, owner, approvals, measures and a review date.
How will it continue?	Routine ownership, training, resources and monitoring after the project ends.

PUT IT INTO PRACTICE

Write a one-page improvement brief

Define the problem, stakeholders, options, pilot, measures and sustainability arrangements. Add one plausible reason the change might fail.

Self-check: What evidence would make you modify or stop the project?

11 Governance, safety and learning



Connect governance to daily practice, respond to concerns and show how learning changes care.

01 Action and assurance
02 Incidents and candour
03 Learning that changes care

11.1 Clinical governance: the practical meaning

Clinical governance is about the systems and culture through which organisations are accountable for quality and continuously improve patient care. In an interview, it is not enough to memorise a definition or list seven historical pillars. Be able to explain how governance works in your day-to-day practice: standards, outcomes, patient experience, risk identification, learning, audit, workforce capability and organisational assurance.

A useful organising framework considers quality through safety, effectiveness and experience, reflecting the 2026 Quality Strategy for NHS-funded care in England. Good governance asks whether care is safe, evidence-based and responsive to people, whether important risks are visible, and whether improvement is maintained. It also asks who is responsible, how information reaches decision-makers and whether staff and patients can speak openly.

The governance cycle

Identify a concern or opportunity; understand the evidence and the relevant standard; take proportionate action; involve stakeholders; measure the impact; review and share learning. This process can apply to medicines safety, consent, diagnostics, documentation, follow-up systems or complaints. Your contribution need not be a dramatic root-cause investigation: routine, sustained improvement also matters.

PREPARATION PROMPT

One example each of identifying risk, improving quality and learning from feedback. Know what changed because of your involvement, and be able to distinguish the work you personally led from work led by the wider organisation.

11.2 Patient safety and PSIRF

The Patient Safety Incident Response Framework (PSIRF) sets out the approach to learning from patient safety incidents in services covered by its requirements. It replaced the earlier Serious Incident Framework and promotes systems-based learning, proportionate responses and compassionate involvement of patients, families and staff. The approach is not simply a new acronym for the old “serious incident investigation”. Its purpose is to improve how an organisation understands risks and turns learning into safer care. PSIRF is an England framework: use the relevant national and employer arrangements elsewhere, as outlined in Chapter 23.

Under PSIRF, organisations need an incident response policy and plan, and should use proportionate learning responses according to their context, risks and priorities. Not every incident requires the same formal investigation. A learning response should explore contributory conditions, including workflows, equipment,

staffing, communication and organisational factors, rather than assume human error is the complete explanation.

An interview answer about an incident should cover immediate patient care and safety, communication with those affected, accurate reporting and documentation, organisational review, learning and follow-through. Mention duty of candour when relevant, but do not imply that every event automatically meets the statutory threshold for a notifiable safety incident. Check the current NHS England standards and the local provider policy before your interview.

Avoid simplistic “root cause” language

Modern safety practice recognises that incidents commonly arise from interactions across complex systems. A single “root cause” can be misleading. Reflect on the work as actually done, how pressures affect decisions and what practical safeguards will make care safer. The panel wants evidence that you can learn without blame while retaining professional accountability.

11.3 Duty of candour, complaints and openness

Candour has both professional and organisational dimensions. The GMC expects healthcare professionals to be open and honest when things go wrong. In England, the statutory duty of candour under CQC Regulation 20 places duties on regulated providers and registered managers, including notification, support, apology, records and written follow-up for qualifying notifiable safety incidents. It is important to distinguish this statutory threshold from the wider ethical expectation of openness.

For a patient complaint, begin by listening and understanding the concern. Consider whether immediate clinical action is required. Acknowledge the patient's experience, explain what you know without speculation, follow the complaints and governance procedures, and help ensure that any learning is shared. Being empathetic does not mean prejudging the findings; being factual does not mean being cold.

Scenario: A patient says a delay in diagnosis caused avoidable harm. A sensible answer addresses current care needs, listens with empathy, ensures accurate records and appropriate senior involvement, considers candour requirements, and supports an appropriate review and follow-up. Avoid promising an investigation outcome before evidence is assessed.

11.4 Patient safety, PSIRF and learning without blame

The Patient Safety Incident Response Framework, or PSIRF, represents an important shift in the way NHS-funded care in England learns from patient safety events. It encourages compassionate engagement with affected patients, families and staff, proportionate responses, system-based investigation and improvement rather than a formulaic investigation of every event. It is not an excuse to ignore poor practice; separate processes may still be required where individual competence, conduct or professional duties raise concerns.

Four points worth knowing: patients and families must be involved compassionately; the response should be proportionate to the learning opportunity and relevant requirements; human factors and system conditions deserve attention; and learning must result in effective improvement rather than simply another policy or training slide. The consultant should know local arrangements for immediate safety action, reporting and escalation and avoid assuming that PSIRF replaces candour or professional accountability.

Imagine a patient suffers harm after a referral result is not acted upon. Protect the patient and respond to their needs, be open through the appropriate candour processes, preserve relevant information and raise the safety concern. Once immediate risks are managed, examine the workflow: where was the result sent, what alerts existed, who was responsible for follow-up, how did workload and digital design affect the situation, and could others be exposed to the same risk? A response focused only on reminding one junior colleague to be careful is unlikely to prevent recurrence.

In an interview, avoid claiming that PSIRF mandates a single investigation method for all incidents. Explain how you would work within the organisation's patient safety incident response policy and plan, support affected colleagues, separate learning from any necessary conduct process, and monitor whether corrective actions actually change risk. The official PSIRF guidance is the appropriate source for detailed obligations.

WORKED CASE

A patient complaint involving possible harm

> “A patient makes a formal complaint alleging an avoidable delay caused serious harm. How would you deal with it?”

WORKED CASE

A patient complaint involving possible harm

What is being tested: Compassion, accountability, candour, procedural fairness, clinical judgement and improvement. The patient needs a meaningful response, not simply a referral to the complaints office.

Approach: First consider any urgent ongoing clinical needs. Listen carefully, acknowledge distress and ensure the patient knows how concerns will be addressed. Establish facts objectively, protect and preserve appropriate records, and follow complaints and safety-reporting processes. Consider both professional openness and whether the organisation's statutory duty of candour is triggered. Ensure suitable senior and governance involvement, communicate without speculation, and support staff involved in the process. Share learning and review whether the resulting changes are effective.

Potential challenge: “Would you apologise before you know what happened?” An apology for distress or the situation can be appropriate without making unsupported assertions about causation or liability. Follow professional guidance and local procedures regarding candour and communication.

Common pitfall: Describing a lengthy investigation while failing to address the patient's immediate care and feelings.

WORKED CASE

Patient safety and PSIRF: moving from blame to learning

What the panel is testing

This tests immediate safety, openness, proportionality and awareness that a patient-safety learning response is not the same as disciplinary adjudication.

A plausible but weak answer

A weak answer begins with “I would conduct a root-cause analysis and find out who made the mistake.” This risks implying that every event has a single root cause, that the doctor personally conducts the formal response, and that blame is the main purpose.

A stronger line of reasoning

A stronger answer begins with the patient: “I would make sure immediate clinical risks are addressed and appropriate senior colleagues are involved. I would ensure accurate documentation and timely reporting, open communication with the patient or family in line with duty-of-candour requirements, and support for affected staff. I would follow the organisation’s PSIRF policy to determine a proportionate learning response. That may involve looking at staffing, medicines systems, interruptions, handovers and safeguards—not simply an individual act. We should translate learning into effective actions and check whether they reduce risk.”

Why this is more convincing

PSIRF seeks proportionate, systems-based learning and compassionate involvement of those affected. Separate processes can still be required for professional conduct, employment, legal or regulatory matters. The candidate should not suggest that PSIRF abolishes accountability.

The follow-up challenge

“Would you investigate every incident fully?” No. Responses should be proportionate and aligned with relevant mandatory criteria, risk profile and the organisation’s response plan. “Would you tell the family immediately that negligence occurred?” Be open about known facts and uncertainty; do not speculate on legal conclusions.

11.5 Explain governance through action and assurance

Governance is not simply the meeting where an issue is discussed. It includes the route by which a concern is recognised, a decision is made, action is owned and the organisation knows whether risk has changed. When discussing governance, use a real example to show this chain. A meeting, report or action plan matters because of what follows from it.

Distinguish operational action from assurance. Fixing an individual problem is action. Checking whether the same risk affects other patients, whether the fix is in use and whether the relevant leaders can see the remaining risk contributes to assurance. A consultant needs to understand both, even when they do not chair the governance committee.

Close the loop after an incident

Immediate response and later learning are different tasks. The first concerns care, safety, communication, documentation and appropriate notification. Later work explores what happened, the contributory conditions and what changes are likely to reduce risk. Do not let the existence of a future review delay current protective action.

Under PSIRF, the learning response should be proportionate and informed by relevant requirements and the local incident response policy and plan. Different methods may be appropriate. A learning response does not determine every issue of individual conduct, employment or professional accountability; those processes may need to run separately with appropriate coordination.

Avoid action plans that only repeat intentions

An instruction to "remind staff" may have a place, but it is rarely a complete response to an unreliable system. Ask why the expected action was difficult or missed. Were responsibilities unclear? Was information available? Did the workflow create interruptions or competing demands? What would make the safer action easier and more reliable?

Each action needs an owner, a timescale and a way to establish whether it helped. Evidence that training occurred is not the same as evidence that practice changed. Do not claim that a new policy closes a risk before checking what happens in everyday work.

IN PRACTICE

From an action list to a safer process

After missed follow-up, the first proposal is to email everyone about checking results. The team instead examines where results arrive, who takes responsibility during leave and how overdue action becomes visible. They retain a targeted reminder, but combine it with explicit cover arrangements and a review of unallocated results.

The interview account explains why those actions address the actual failure points. It also identifies how the team will check for unintended workload and whether the arrangements remain workable.

Use complaints as evidence without reducing people to data

A complaint may reveal harm, a communication failure, unmet expectations or a mismatch between different accounts. Listen before defending the service. Clarify what the person is concerned about and what they need now. Provide an appropriate explanation of the process, avoid speculation and keep promises about contact and follow-up realistic.

A complaint's value is not limited to whether it is formally upheld. Patterns in communication, access or continuity may be useful even where individual clinical care was reasonable. Conversely, patient satisfaction does not by itself establish that care was safe or effective. Bring different forms of evidence together.

Be precise about candour

The professional duty of openness is not identical to the statutory provider duty. Do not attempt to recite legal thresholds from memory unless the question genuinely requires them and you know them accurately. Explain that you would act openly, seek appropriate support and follow the applicable professional and organisational requirements. Saying sorry is not a substitute for explaining, supporting and following through.

FOUR-POINT BRIEF

Patient safety, incidents and PSIRF

- PSIRF focuses on learning and improving systems, rather than automatically investigating every incident in the same way.
- Those affected, including patients, families and staff, deserve compassionate engagement and meaningful involvement.
- Responses should be proportionate and use methods suited to the learning question, including thematic approaches where appropriate.
- Learning only matters when it leads to actions, measurement and better care, with appropriate oversight and accountability.

Consultant lens: Explain how you would protect patients now, support those affected and turn an incident into demonstrable improvement.

PUT IT INTO PRACTICE

Follow a governance concern to closure

Choose a real concern and explain the route from recognition to action, review and assurance. Identify who owned each step.

Self-check: Did the work demonstrate safer practice or only completion of an action plan?

12
Teaching, research and professional development



Explain your educational and academic contribution and prepare for the wider responsibilities of consultant practice.

01 Teaching and supervision
02 Research and evidence
03 Development and job planning

12.1 Teaching, supervision and developing others

Consultants contribute to a learning culture through supervision, informal teaching, feedback, assessment and role-modelling. Teaching quality is not measured simply by the number of lectures delivered. Good educators identify learners' needs, set objectives, use suitable methods, create psychological safety, give actionable feedback and evaluate whether learning has transferred into practice.

For “How do you know you are a good teacher?”, offer evidence of impact: learner feedback with examples of resulting changes, repeat invitations, assessment outcomes where appropriate, peer observation or changes in learner confidence and capability. For “How would you improve teaching here?”, consider protected time, the trainee experience, multiprofessional education, faculty development and delivery methods that fit local workflows.

Distinguish teaching, supervision, mentoring and coaching. Teaching develops knowledge and skills; supervision adds oversight and accountability for practice; mentoring supports broader development through an ongoing relationship; coaching helps an individual reflect and find solutions. These functions may overlap, but naming them correctly helps you explain your approach.

12.2 Research, innovation and academic credibility

Research matters differently across consultant posts. In some, developing a research programme and securing funding will be central; in others, scholarly practice, recruitment to studies, critical appraisal or applying evidence to local pathways may be more relevant. The panel needs to know what you actually contributed and why that contribution matters.

Know how to discuss a study's question, design, main finding, limitations and implications without overstating causality or clinical significance. If you have limited formal research output, discuss evidence-based practice, audit, improvement or collaboration honestly rather than inventing academic ambition. For academic posts, be ready to describe a credible research trajectory, collaborators, methods, protected time and likely outputs.

Innovation is not synonymous with technology. It may mean a better pathway, a changed workforce model or a more inclusive service. Show how you evaluate safety, effectiveness, equity, cost, implementation and sustainability. The ability to challenge an attractive but poorly evidenced idea can be as important as the ability to generate one.

12.3 Appraisal, revalidation and job planning

The consultant role requires ongoing professional development and reflection. Appraisal is a structured process for reviewing work and development; revalidation is the GMC's periodic confirmation that a doctor remains fit to practise, supported by the relevant governance and appraisal arrangements. The details depend on the doctor's designated body and responsible officer arrangements; do not present appraisal as a one-off annual tick box.

Job planning is the agreement between consultant and employer about NHS duties, programmed activities, objectives and supporting resources. In the standard full-time 2003 England consultant contract, ten programmed activities (PAs) is a reference point, ordinarily with four-hour PAs subject to contractual rules. Duties may include direct clinical care (DCC) and supporting professional activities (SPA) such as training, professional development, audit and governance. The appropriate split must be established through the relevant contract, role and local agreement; do not assert that every consultant has the same DCC/SPA ratio.

At interview, show that you understand the job description, clinical commitments, on-call arrangements, supervision, supporting professional responsibilities and the need to agree realistic objectives and resources. A thoughtful question about how the department supports SPA time is more useful than simply asking how many sessions you will be paid for.

WORKED CASE

A struggling trainee

What is being tested: Supervision, early recognition of risk, educational leadership, welfare, fairness and use of organisational processes.

Approach: Establish the nature and impact of the concern and whether immediate supervision or changes to duties are needed to protect patients. Seek objective examples rather than relying on reputation. Have a private, supportive and clear conversation; explore learning needs, workload, health or personal difficulties without pressuring the individual to disclose private information. Involve educational supervisors or training leads where appropriate, agree expectations, support and review dates, and document relevant professional actions. If progress remains inadequate, use the formal educational and employment routes while maintaining dignity.

Potential challenge: “What if the trainee says they are being bullied?” Take the concern seriously, consider independent support and fair investigation, and avoid treating the complaint as proof of poor performance. Safety and fair process must both be addressed.

Reflection: How would your approach differ for a one-off error, a persistent skills gap and suspected deliberate misconduct? These require different levels of action and oversight.

12.4 Show how you teach, not just how often

A teaching portfolio becomes persuasive when you explain the educational decisions behind it. Who were the learners? What did they need to be able to do? How did you establish the starting point? Why did you choose that method, and how did you know whether it worked? A long list of sessions without these decisions may show commitment but little educational insight.

For adult learners, connect teaching to a relevant task, draw on prior experience and make the purpose clear. Active participation and opportunities to practise can reveal misunderstandings that a lecture alone may miss. These are practical design considerations, not a requirement to recite several named theories in every answer.

Plan around an observable objective

"Understand handover" is difficult to evaluate. "Give a structured handover that identifies outstanding actions and ownership" is more observable. Choose a method that lets learners practise the required activity, then offer feedback on it. If the objective concerns judgement, discuss uncertainty and competing options rather than only factual recall.

Adapt to the learner and setting. A novice may need a clear demonstration and close supervision; an experienced colleague may benefit from analysis of a complex case. Do not infer competence from seniority alone or lack of interest from a quiet style. Ask questions that reveal understanding without turning teaching into public humiliation.

Give feedback that changes the next attempt

Describe the observed behaviour, explain its effect and invite the learner's view. Agree one or two specific changes and an opportunity to try them. "Be more confident" gives little direction. "State your assessment before listing all the findings, then make the proposed next step explicit" is something a learner can practise.

Feedback is not always comfortable, but it should be respectful and proportionate. Private discussion is usually appropriate for sensitive performance concerns; immediate safety correction may be necessary in the clinical setting. Explain the difference and return later to the learning conversation.

Understand assessment without overclaiming

Formative assessment primarily supports learning; summative assessment contributes to a progression or certification decision. Workplace-based assessments can support observation, discussion and feedback, but their usefulness depends on how they are conducted and interpreted. A completed form is not the same as a careful assessment of performance.

When asked about assessment quality, consider whether it addresses the intended capability, samples enough performance, uses clear criteria and provides useful feedback. No single observation should be portrayed as proving competence in every setting. Follow the relevant training programme's requirements rather than inventing a universal rule for all specialties.

IN PRACTICE

Positive feedback, limited evidence of learning

A candidate reports that a teaching session received excellent satisfaction scores. On further discussion, they realise that the survey did not show whether learners could perform the task. They add an observed practice activity and follow-up feedback to the next session.

The stronger interview answer acknowledges the limitation of the original evaluation and explains how it changed the design. It does not dismiss satisfaction, but distinguishes enjoying a session from achieving its objective.

Create psychological safety with standards

Make it possible to ask questions, admit uncertainty and challenge respectfully. Explain how to obtain help and what level of supervision applies. Respond to errors by addressing safety and understanding what happened, not by using embarrassment as a teaching method. Psychological safety does not mean that performance is never assessed or that poor practice is ignored.

When a learner struggles, establish the specific difficulty, consider workload and wellbeing, review the learning environment and agree appropriate support. Involve the educational or clinical supervisor and relevant training structures where needed. Do not promise to keep information confidential where patient safety or formal responsibilities require action.

Explain your research contribution accurately

Describe the research question, your role, the design, the principal finding and the limitations. Be clear about authorship and collaboration. Participation in recruitment is not the same as designing a study; first authorship does not automatically mean you performed every component. Honest precision is more credible than trying to inflate your role.

Discuss what the findings mean for practice and what remains uncertain. A statistically significant finding is not automatically a clinically important effect. A study conducted in a different population may require caution before local adoption. Where research is central to the post, explain the infrastructure, collaborators, feasibility and protected time needed for your proposed programme.

Be constructive when your research experience is limited

Do not invent a research ambition because you think every consultant must lead a major programme. Explain relevant critical appraisal, evidence-based practice, participation in studies or opportunities for collaboration. Distinguish research, audit and improvement, and use the relevant governance route for the activity. A credible contribution matches the job rather than an imagined academic ideal.

Treat your job plan as a delivery agreement

Discuss the responsibilities, objectives and resources that make the role deliverable. Direct clinical work, supervision, teaching, development and governance all consume time. A promise to take on unlimited additional projects may suggest that you have not considered the practical demands of the role. Understand local arrangements and the applicable contract; do not assume a universal split of activities.

Appraisal should help you review the whole of your practice and plan development. Revalidation is a related regulatory process, usually on a five-year cycle, rather than an annual interview or a guarantee that concerns never arise. Concerns about practice should be addressed when they arise, not saved for the next appraisal.

PUT IT INTO PRACTICE

Evidence your educational contribution

Prepare one teaching example, one learner-support example and a concise research contribution. State the limits of the evidence for impact.

Self-check: Can you distinguish satisfaction, learning and change in practice?

13
Preparing and delivering a presentation



Build a persuasive argument, design usable slides and deliver confidently within the brief.

01 Decode the brief | 02 Build the argument | 03 Rehearse and handle questions

13.1 Presentations: a clear argument, not a slide collection

Consultant presentations often test your ability to explain priorities to a mixed audience. Start by defining the problem and your main message; then develop two to four supporting points; finish with a realistic next step. A presentation on “your vision for the service” should contain evidence of local understanding, stakeholders, resource constraints and measures of success. A presentation about your achievements should explain contribution and impact, not just list posts and certificates.

Plan backward from the allotted time. Leave space for a strong opening and closing, and rehearse aloud with a timer. For short presentations, avoid slides that look like a written essay; use one message per slide, readable visual hierarchy and only essential data. Describe numbers accurately and do not present speculative benefits as outcomes already achieved.

Suggested seven-slide architecture for a service-development topic: title and clear thesis; local challenge; aims and patient benefit; proposed approach; workforce and operational dependencies; measurable outcomes and risks; practical first steps. Seven slides may be too many for a very short slot and too few for a longer one: let the time allowance determine the format.

Presenting a service vision with evidence and restraint

A vision should be more than enthusiasm for innovation. Begin with what you understand about the population and current pathway, being clear what is established and what you still need to learn. Identify a small number of priorities supported by patient need, service data and wider NHS direction. For each priority, explain intended benefit, stakeholders, dependencies, risks and the measure of success. A panel will often value a credible first year of contribution over a grand five-year promise that ignores workforce and finance.

If the presentation title is “How would you improve our service?”, do not imply you have discovered all its weaknesses through a website visit. A constructive formulation is: “From the information available, these appear to be areas worth exploring with the team. My first step would be to validate the baseline and understand what staff and patients see as the main barriers.” This combines preparedness with humility. Avoid using a slide full of acronyms to create an impression of strategic sophistication.

A five-slide worked architecture

Slide 1 states the challenge and why it matters to patients. Slide 2 summarises the local context, including gaps in your knowledge. Slide 3 outlines two or three priorities and explains why you chose them. Slide 4 deals with implementation, the people needed, risks and measures. Slide 5 gives a realistic sequence of first steps and a concise closing message. The number of slides is illustrative; the organising logic matters more than the format. Rehearse transitions, not only individual slides, so the presentation sounds like an argument rather than separate fragments.

13.2 Presentation masterclass: from title to confident delivery

A short consultant presentation is a test of selection, judgement, communication and leadership. The panel usually knows that you can find information. It wants to see whether you can choose what matters, make a

convincing argument for a mixed audience, balance ambition with realism and communicate under time pressure. A five-minute presentation is not a compressed thirty-minute lecture.

Step 1: Decode the exact wording of the title

Underline the action verb: describe, evaluate, prioritise, develop, lead or improve. Identify the subject, the organisational level and the time horizon. “What are the challenges facing the specialty?” requires diagnosis and prioritisation; “How would you develop this service?” requires decisions and an approach; “Your first year as consultant” requires a credible sequence. Clarify whether slides are permitted, how long you have, and whether there will be questions. Do not assume that every presentation permits PowerPoint.

Step 2: Define the single central message

Write one sentence that expresses your argument. For example: “My priority would be to improve access without compromising safety, through clearer triage, a better supported workforce and reliable measurement.” Every subsequent point must support that sentence. Resist the temptation to prove how much you know by including twelve themes.

Step 3: Learn enough about the local service to avoid generic claims

Use the job description, trust strategy, annual reports, published quality and performance information, specialty standards and what you learnt in appropriate conversations. Separate known facts from assumptions. It is safer to say “I would want to examine referral variation with the team” than to announce that referrals are mismanaged. Where data are unavailable, name the question you would investigate.

Step 4: Use a persuasive three-part architecture

Opening: name the problem and your thesis. Middle: develop two or three priorities, each with its rationale, practical actions, stakeholders, likely barriers and a measure. Closing: return to patient benefit, partnership and delivery. If asked for a vision, connect it to CPR: the change you want to create, the people you will engage, and the result you will track.

Step 5: Design slides for the audience, not for the speaker

If slides are allowed, use one idea per slide and make every title an assertion rather than a label. Prefer a simple pathway diagram, three concise priorities or a small readable chart to densely packed text. Keep data sourced and legible. Avoid decorative clinical imagery, animations and complicated tables. Slides are visual support; your spoken narrative carries the argument. For a no-slide presentation, the same structure should be easy to remember through three verbal signposts.

Step 6: Rehearse for timing and interruptions

Rehearse aloud repeatedly with a timer, not just silently. Aim to finish comfortably within the published limit. Record a rehearsal and check pace, filler words, transitions and whether the conclusion survives. Practise an alternative version that is 30 seconds shorter. If interrupted, acknowledge the question, answer it briefly and return to your central message. Do not insist on finishing every prepared line.

IN PRACTICE

A presentation that makes choices

A candidate has five minutes to discuss “The future of our outpatient service”. Their first draft contains 19 slides of national statistics. They replace it with a one-sentence vision, three priorities (safer triage, equitable access, workforce capacity) and a measurement plan.

The shorter version is more strategic because it makes choices and acknowledges the local evidence still needed.

Illustrative five-minute running order

0:00–0:30: opening and headline message. 0:30–1:15: what matters locally and what you still need to learn. 1:15–3:55: three priorities, allowing about 50 seconds each. 3:55–4:35: how you would work with colleagues, manage constraints and measure progress. 4:35–5:00: compelling conclusion. Adjust to the actual title; the timings are a guide, not a compulsory formula.

Prepare for questions after the presentation

Anticipate challenges about funding, staffing, equity, patient safety, timescale and feasibility. Prepare evidence for each priority and be ready to revise your approach when the panel supplies new information. If challenged on local detail, distinguish what you know from what you would validate. Avoid defending a proposal so aggressively that the panel concludes you cannot listen.

Common presentation errors

Starting with a long biography; listing national policies without local application; proposing expensive changes without a business case; speaking over slides; cramming the final minute; using jargon that excludes lay panel

members; making unsupported criticism of the department; and forgetting to state what success would look like.

PRACTICE INSERT

Rehearse the presentation and the follow-up

Ask a colleague to score your presentation on five dimensions: answer to the title, clarity of the central message, practical consultant contribution, credibility of evidence, and delivery within time. Invite one uncomfortable follow-up and practise answering it calmly.

WORKED CASE

Explaining a service vision in five minutes

What is being tested: Ability to prioritise, think strategically and translate NHS direction into a feasible local plan. A vision is not a wish list of equipment, new clinics and extra staff.

Approach: Start with an overarching purpose such as safe, equitable and timely care. Identify two or three priorities grounded in the role and the available service information. Acknowledge strengths worth retaining and the voices of patients and staff. Explain an approach: understand baseline performance, agree a shared goal, review options, make a business case where necessary, test delivery and monitor outcomes. Connect the proposed direction to relevant aspects of the 10 Year Health Plan without forcing all three shifts into an unrelated problem.

Potential challenge: “How will you fund it?” Explain that feasibility and options appraisal would precede commitments. Recognise workforce and capital/revenue implications, plus possible redesign within existing resources. Do not invent a financial benefit or promise new capacity before knowing the constraints.

Presentation exercise: Reduce your answer to one sentence, then to three labelled priorities with a measure beside each. If the list runs to 12 priorities, you have not yet made the strategic choice.

13.3 Build the presentation backwards from the decision

Before opening presentation software, ask what you want the panel to understand, believe or discuss by the end. Then check that this matches the title. A presentation about your contribution is not the same as a presentation about the future of the specialty. A presentation about improving a pathway is not an invitation to list everything wrong with the NHS.

Write a one-sentence answer to the title. Under it, identify two or three arguments that support the answer. For each argument, record the evidence, an action or proposal, a limitation and how success could be assessed. Only then decide what the audience needs to see on a slide.

Decode the brief precisely

Check the duration, whether slides are permitted, the audience, file format, submission deadline and whether questions are included within the time. Identify the action in the title: evaluate, propose, reflect, prioritise or explain. If a brief is genuinely ambiguous, ask the recruitment contact a focused question rather than designing a presentation around an untested assumption.

A five-minute presentation cannot contain a full service strategy. Select the priorities that matter most and show how you chose them. Leaving out a topic deliberately is better than mentioning ten topics so briefly that none contains reasoning. Prepare additional detail for questions rather than squeezing it into the spoken presentation.

Give the audience a map

Open with the central message and the route through it. For example: "My priority would be a more reliable pathway, built around clearer decisions, better communication between teams and measures that show whether patients benefit." The next sections should deliver those promises in the same order.

A useful transition explains the relationship between ideas: "A clearer process will not work unless colleagues can use it within their current workload." This is stronger than "My next slide is about staff." The conclusion should return to the title, summarise the priorities and identify the practical first step or principle.

Use evidence proportionately

Use a small number of relevant, verified facts. Distinguish national evidence, local published information and assumptions you would validate after appointment. Give the source and date for figures on slides. Do not use an attractive statistic that you cannot explain or a local comparison with unclear definitions.

When proposing change, identify the dependency that could make it fail. This might be staffing, diagnostic access, commissioning, training or the quality of information. Acknowledging a dependency makes your plan

more credible when you also explain how you would address it. Avoid presenting uncertainty as a reason to offer no direction at all.

Design slides that can be read at a distance

The handbook uses 10-point body text for reading; a projected slide should not copy that density or font size. Use large, legible text and test it from the back of a room or at a reduced window size. One principal message per slide is a useful discipline, not an inflexible rule. Keep labels, charts and source notes readable.

Prefer a simple pathway, a small comparison or three clearly distinguished priorities to a page of prose. Avoid decorative photographs with no explanatory purpose, complicated animations and tables that require the audience to read while you are speaking. Maintain strong contrast and do not rely on colour alone to communicate meaning.

WORKED EXAMPLE

A five-minute service-development presentation

Opening: state the patient or service problem and your central proposal.

Priority one: make the pathway reliable. Explain a specific point to investigate and how the team would test an improvement.

Priority two: make the change workable for people. Explain involvement, workload, training and ownership.

Priority three: demonstrate benefit. Explain a small set of outcome, process and balancing measures, including equity where relevant.

Close: identify the first practical step and acknowledge the key dependency. This is an illustrative architecture; the actual title must determine the content.

Prepare a presentation without slides

The structure matters even more when there is no visual guide. Use a clear opening, numbered verbal signposts and short transitions. A small prompt card may help if permitted, but reading a script can weaken engagement. Practise the opening and closing carefully, and know the purpose of each middle section rather than every sentence.

Do not compensate for the lack of slides by speaking faster. Give the listener time to recognise the structure. For a complex proposal, a brief repeated phrase can provide orientation: "the process, the people and the proof of benefit". Use language that feels natural to you rather than a slogan that distracts from the argument.

Rehearse for the real conditions

Rehearse aloud with a timer and the actual slides or prompts. Speaking time is not the same as silent reading time. Build a small margin below the limit so a pause or transition does not remove your conclusion. There is no need to aim for a particular words-per-minute figure; use a pace that remains clear under pressure.

Test a shorter version. Decide which example or detail can be omitted without damaging the central argument. Practise a technical failure, an interruption and a challenging question. Save an appropriate backup and follow the employer's submission instructions rather than assuming that your own laptop or internet access will be available.

Handle questions as part of the presentation

Listen to the entire question and identify the concern behind it. A question about cost may be about feasibility; a question about evidence may be about overconfidence. Answer directly, acknowledge a valid limitation and explain how you would resolve uncertainty. Do not respond to a short challenge by delivering the entire presentation again.

If new information changes your proposal, say so. "That would alter my proposed starting point" can demonstrate judgement. It is usually stronger than defending a plan that depended on an assumption the panel has just corrected. Where you do not know, explain the information required and how it would affect the decision.

PUT IT INTO PRACTICE

Rehearse the actual presentation

State the central argument, time a full rehearsal and practise a shorter version. Ask someone to challenge funding, feasibility and local assumptions.

Self-check: Does the conclusion answer the title and survive an interruption?

14 Handling NHS issues at interview



Prepare three or four substantive points per issue, then apply them to the service and your own contribution.

01 Three or four key points | 02 Local implications | 03 Consultant contribution

14.1 NHS issues at interview: four points, not forty

You do not need to read every strategy, press release, performance report or consultation in full to give an excellent NHS-awareness answer. Nor should you try to impress the panel by listing initiatives and acronyms. Your task is to show that you understand the direction of the NHS, can select the issues that matter and can translate national priorities into sensible decisions for patients and your department. This is a test of perspective and judgement, not a memory examination. For a post outside England, use Chapter 23 to select the relevant national context before applying these techniques.

A good way to prepare is to build a one-page briefing for each relevant issue. Learn a one-sentence explanation, three or four anchor points and one example of its implications for your specialty. The anchor points help you think clearly; they are not a script to recite. Your knowledge should be up to date, but it does not need to be encyclopaedic.

The four-part answer: from national issue to local contribution

Stage	What the panel should hear
1 | Headline	Identify the issue and explain its purpose or main challenge in plain English.
2 | 3–4 points	Select the few principles, pressures or developments that genuinely matter.
3 | Local impact	Connect it to patient care, outcomes, staff, access, resources and your specialty.
4 | Consultant view	Offer a balanced priority, practical contribution or sensible next step; acknowledge one real trade-off.

Think of this as a 60–90 second answer, with space for the panel to ask follow-up questions. If the question is broad, choose the points most relevant to the post; if it is narrow, go deeper on the area requested. Do not force all four stages into every sentence.

How much NHS reading is enough?

- Start with one authoritative summary: for a major policy, read the NHS England or GOV.UK executive summary or main priorities, rather than every appendix.
- Know the local picture: study the employing organisation’s strategy, relevant performance indicators and the department’s most important challenges. The local connection often matters more than another national statistic.

- Prioritise intelligently: prepare the major national themes, then choose two or three topics particularly relevant to your specialty and advertised service.
- Refresh near the interview: check for significant changes in the preceding few weeks, but do not fill your final 24 hours with unstructured news consumption.

The difference between understanding a policy and reciting one

A panel is not an examination board testing whether you can repeat a government document. Questions about NHS reform are usually a way of seeing whether you understand the environment in which consultants work and can translate general principles into sensible clinical decisions. The three questions behind many NHS questions are: Do you know what matters? Can you identify the implications and trade-offs? What would you contribute in this department?

A useful answer is built from four layers. Begin with an accurate headline, in plain English. Identify three or four key points worth remembering. Translate one or two into practical effects on your specialty, patient pathway, workforce or resources. End with a considered position: what should happen first, what could go wrong, who should be involved and how would you know it worked? This is an approach to thinking, not a fixed verbal formula or a requirement to use four separate paragraphs.

The depth must fit the question. An invitation to “outline the priorities of the 10 Year Health Plan” may need under a minute. A question about redesigning a neighbourhood pathway might require several minutes of reasoning. Do not preface a focused answer with every national strategy you remember. The panel is asking you to select, not download, information.

The preparation triangle: national, organisational and local

Before an interview, prepare at three levels. At national level, know the direction of travel and a handful of key frameworks relevant to your specialty. At organisational level, read the Trust's strategy, quality and performance reports, and understand important workforce or financial constraints. At department level, investigate the service's clinical strengths, access pressures, staffing, training responsibilities, patient population and proposed developments. The most convincing answer joins these levels together, rather than giving a generic national lecture that could be delivered at any hospital.

Do not collect statistics indiscriminately. One current, directly relevant local figure may be more valuable than ten unconnected national targets. Confirm the period, definition and direction of any performance figure before quoting it; if you are unsure, state the principle and say what you would verify. Remember that a Trust can have a particular pressure that differs from the national picture, and that the relevant health-system arrangements differ across the four UK nations. This chapter primarily discusses England.

How to respond to a challenge or disagreement about policy

Panels may ask, “Do you agree with that policy?” or “Is it realistic?” Avoid reflexively praising or attacking it. Separate the strategic intention from the implementation. State what benefits you see, what conditions are necessary to achieve them and where risks require mitigation. For example, shifting care closer to home may be advantageous for many patients but can fail if diagnostic capacity, workforce, data-sharing, escalation pathways or funding do not follow. A mature consultant can support the direction of travel while challenging unsafe details constructively.

When you cannot recall a policy detail

Do not invent the name, publication year or numerical target of a document. It is usually more credible to acknowledge a specific gap and demonstrate reasoning. For instance: “I cannot quote the exact target and would check the latest guidance before using it for planning. The relevant principles are access, patient safety and the sustainability of the pathway. Locally, I would start by reviewing our baseline and discussing the options with the MDT and management team.” The absence of one fact should not lead to a five-minute apology or to pretending you know something you do not.

Three different levels of preparation

Essential: know what the 10 Year Health Plan seeks to change, the quality and safety principles relevant to your work, and the main challenges facing your future service. Strong: add the Trust's recent priorities, a few credible performance measures and a practical example for the main national themes. Distinctive: develop thoughtful positions on difficult trade-offs, link them to your own experience and anticipate probing questions. The third level is about thinking better, not reading more PDFs.

What a strong answer actually sounds like

QUESTION
“What does the 10 Year Health Plan mean for your department?”

A weaker answer lists all three shifts and then describes several initiatives with little local relevance. A stronger answer might say: “For our specialty, the shift that could make the biggest immediate difference is bringing appropriate follow-up closer to home. That would need clear patient-selection criteria, access to diagnostics and reliable escalation back to hospital. I would want to work with community colleagues and patients to design a small pilot, then look at outcomes, patient experience and any unequal impact before expanding it. Digital support could help, but only if it did not exclude patients who cannot use it.”

Why it works: the answer establishes national awareness, selects relevant points, anticipates a practical difficulty and shows how a consultant thinks. It does not pretend to be an implementation plan.

QUESTION

“How should consultants respond to NHS financial pressures?”

A good answer could begin: “I think consultants have a responsibility to use resources wisely without compromising safety or equity. I would first understand the actual cost and demand drivers in the service, then work with the team to identify unwarranted variation, duplication and opportunities to improve pathways. I would compare options and assess risks, not assume that shorter consultations or reduced staffing automatically represent efficiency. Whatever we change, I would monitor outcomes, patient experience and any unintended consequences.”

The critical difference is that the candidate is offering judgement rather than a list of generic savings.

What if you do not know the answer?

An interview panel will not expect encyclopaedic recall. It will, however, notice when a candidate confidently invents a fact, gives outdated information or answers a different question. If you cannot remember a policy detail, acknowledge that limitation briefly, explain the principle you do understand, and move to a relevant local implication. For example: “I would not want to quote the precise national target without checking it, but the practical issue for our service is reducing avoidable delay while protecting quality. I would start by looking at our baseline, the patient pathway and the barriers to timely care.”

Do not hide behind “I would look it up” as the whole answer: the panel still wants to hear how you reason. Equally, avoid turning an answer into a long disclaimer. A short, calm admission of uncertainty can strengthen credibility.

A full worked answer - patient flow under pressure

WORKED EXAMPLE

“The hospital is experiencing serious bed pressure. How might you contribute as a consultant?” Start with the underlying principle: the aim is timely, safe care rather than discharge for its own sake. Explain briefly that flow depends on assessment, diagnostics, specialty decisions, therapies, pharmacy and community support, so blaming one team is unhelpful. Within your own service, you could examine delays to consultant decision-making, preventable investigations, clear escalation criteria, planned discharge and communication with community colleagues. Say how you would involve nurses, junior doctors, allied health professionals and operational staff. Acknowledge that some patients cannot be discharged safely without support, and that pushing an unsafe discharge creates additional risk and may worsen demand later. Finish with measures: delayed decisions, length of stay adjusted for case mix where possible, readmissions, safety events, patient experience and workforce effects. The strength lies in the chain of reasoning and practical limits, not in pretending you can solve the entire hospital's bed position.

A full worked answer - difficult choices about the use of resources

WORKED EXAMPLE

“The department wants to invest in a new piece of equipment. How would you argue for it?” Begin with the patient or service problem and the evidence that the present arrangement is inadequate. Compare plausible alternatives, including changes to the pathway or better use of existing equipment. Examine the full financial and operational case: purchase cost, maintenance, staffing, facilities, training, consumables and whether sufficient activity exists to justify the investment. Show how you would involve finance, managers, procurement, clinical engineers where relevant, patient representatives and the multidisciplinary team. State the benefits you would test: safety, quality, timeliness, patient experience, productivity and potential inequality impacts. Acknowledging that a desirable clinical intervention may not be the best use of constrained resources is part of consultant-level judgement, provided that you are willing to challenge decisions that compromise patient safety.

The 90-second challenge

Select a national issue. Give yourself 20 seconds to explain what it means, 30 seconds to identify the most important considerations, 25 seconds to describe the implication for the advertised department and 15 seconds to state a realistic first step or judgement. Then practise a three-minute version in which a colleague probes you on risk, evidence, finance, staff involvement or implementation. The shorter answer proves that you can prioritise; the longer response proves that there is real depth behind the summary.

Your seven-topic revision plan

For the final week, be prepared to discuss: (1) the 10 Year Health Plan; (2) your specialty's access and performance challenges; (3) quality, safety and PSIRF; (4) finance and productivity; (5) workforce and compassionate leadership; (6) EEDI and health inequalities; and (7) digital transformation/AI. Add one or two local or specialty-specific topics and be ready for related questions about integrated care or prevention. Each needs four anchor points, one specialty example and one considered view. This is enough to enter an NHS-awareness discussion with confidence without trying to memorise the entire NHS.

Check these official sources when updating your preparation: the GOV.UK 10 Year Health Plan for England; NHS England Medium Term Planning Framework 2026/27–2028/29; NHS England PSIRF; the July 2026 Quality Strategy for NHS-funded care in England; and GOV.UK NHS staff standards (July 2026). Verify publication updates and your Trust's local strategy before the interview.

14.2 Use the handbook to reduce your reading burden

A comprehensive handbook should make preparation more selective, not persuade you that every page must become a memorised answer. Start with the issues most relevant to the advertised role. For each, prepare three or four important points, understand why they matter and identify a realistic consultant contribution. Read more deeply when the job or the question requires it.

The important distinction is between a short answer and a shallow answer. "There are workforce pressures" is short but offers little analysis. "Retention is affected by whether the work is sustainable, whether staff are supported and whether they have opportunities to develop; I would examine those factors alongside recruitment" contains several usable ideas. You should be able to expand each if asked.

Keep a one-page topic brief

Record the issue in your own words, the three or four main points, a local implication, a practical contribution and a genuine trade-off. Add the source and date of any policy or figure. The brief should support conversation rather than resemble a miniature policy document. Do not include a number unless it improves the argument and you can explain its scope.

When revising, close the source and explain the topic aloud. If you can only repeat a phrase such as "integrated neighbourhood working", you have not yet translated it into practice. Describe what would change for a patient, a colleague or a decision. This is the bridge from policy awareness to consultant-level judgement.

INTERVIEW INSIGHT

An unfamiliar policy is not a reason to bluff

Where you recognise the general issue but not a named document, say so briefly. Clarify the question if necessary, then discuss the principles you can address accurately. Do not invent a policy requirement or imply that a proposal has already been implemented. Distinguishing knowledge from uncertainty is part of a credible answer.

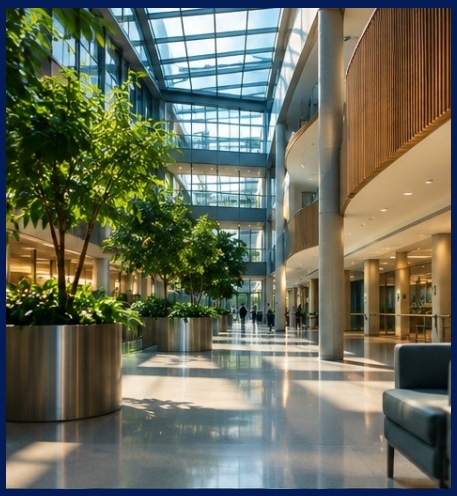
PUT IT INTO PRACTICE

Build a topic brief

Prepare four key points on an issue relevant to your post, with a local implication, your contribution, a trade-off and a dated source.

Self-check: Can you expand the points without turning the answer into a policy lecture?

15
NHS systems, strategy and partnership



Understand the direction of travel, distinguish plans from implementation and think across organisational boundaries.

01 The system around the service
02 National direction
03 Partnership and accountability

15.1 Understanding the NHS around your department

A consultant works in a network of organisations, not an isolated hospital. In England, NHS trusts and foundation trusts provide services and have boards responsible for governance and performance. Integrated care boards (ICBs) plan and commission services for their populations and work with partners across a wider integrated care system. Local authorities, primary care, community services, mental-health providers, ambulance services and the voluntary sector are important partners. The exact local structures and accountabilities change over time.

National and local structures are changing. As at 15 November 2026, the Health Bill provides for abolishing NHS England and transferring its functions; a proposal in legislation is not the same as a completed change. Check current responsibilities and your local ICB arrangements rather than memorising a fixed organisational chart.

A simple system map

Level	Questions to understand
National	What priorities, professional standards and regulatory duties shape care?
System / ICB	What health needs, commissioning arrangements and shared priorities affect this population?
Organisation	What are the Trust's strategy, performance pressures, workforce plans and quality priorities?
Division / specialty	What are the service's access, quality, productivity and staffing challenges?
Front line	What will patients and colleagues experience differently if a change succeeds?

A strong NHS-awareness answer connects national direction → local challenge → action you can influence. Reciting national policy with no local implication is not strategic awareness.

15.2 The 10 Year Health Plan and the three shifts

The 10 Year Health Plan for England, published in July 2025, sets a strategic direction around three shifts: hospital to community, analogue to digital, and sickness to prevention. It also sets ambitions around a revised operating model, transparency, workforce, innovation and finances. These are broad directions, not a guarantee that every service will move in the same way or at the same speed.

Strategic shift	Possible consultant-level implications	Questions a panel may ask
Hospital → community	Appropriate care closer to home; coordinated pathways; specialist input across settings	What can safely move out of hospital, and what support would it need?
Analogue → digital	Better information, access and workflow; digital inclusion; safe governance	Where could technology improve the patient journey without excluding people?
Sickness → prevention	Earlier intervention, risk reduction, population health and inequalities	How could your specialty contribute to prevention and earlier care?

The best answers are balanced and practical. Community-based care can improve experience and accessibility but may require workforce, diagnostics, referral pathways and reliable escalation. Digital tools can reduce administrative friction yet create new safety, privacy and equity risks. Prevention is valuable, but investment decisions must consider evidence, implementation and the effect on existing services.

Practice question: “What does the NHS 10 Year Health Plan mean for your specialty?” Prepare one specific example for each shift, then identify the main implementation barrier and one credible next step for the local department.

What the three shifts could mean in an actual specialty

HOSPITAL TO COMMUNITY does not mean that all outpatient work should leave hospital. It means asking which care could be delivered more accessibly and safely closer to home, and what hospital-based expertise and facilities remain essential. For a consultant considering a redesigned follow-up pathway, this may involve shared protocols with primary care, community diagnostics, clear criteria for re-referral, rapid advice and guidance, and patient involvement. An attractive proposal can still be unsafe if responsibility is unclear or community teams lack capacity.

ANALOGUE TO DIGITAL is not synonymous with buying an AI application. Digital improvement may start with reliable referral information, interoperable records, booking systems, patient communication or reducing duplicate manual work. The consultant's contribution is to clarify the clinical workflow, understand human factors and make sure technology supports rather than obstructs patient care. Ask who benefits, who might be excluded, who checks the output and what happens when the system fails.

SICKNESS TO PREVENTION requires attention to avoidable deterioration and wider determinants of health, not simply a new health-promotion poster. Depending on specialty, priorities could include earlier diagnosis, secondary prevention, medicines optimisation, smoking cessation, reducing missed appointments or interventions that prevent repeat admissions. Prevention may deliver benefits over a long horizon, so establish realistic evaluation measures rather than claiming immediate cashable savings.

Worked discussion: “What are the implications of the 10 Year Health Plan for your specialty?”

A high-quality answer begins by naming the three shifts briefly, then chooses the one or two with the greatest local relevance. Suppose your service has growing routine follow-up demand. You might explore which patients genuinely require consultant review, how a supported community follow-up model could work, whether remote monitoring is clinically valid, and what safeguards protect patients with complex needs or poor digital access. Acknowledge the implications for specialty training, community staffing and clinical accountability. End with an achievable next step: map current follow-up demand and outcomes with patients, GPs, nurses and administrative colleagues, test a defined cohort, and monitor safety, access and experience. The point is not to invent a solution from the interview chair. It is to demonstrate how you would make a responsible decision.

The important distinction: aspiration is not implementation

National strategies express intentions; they do not guarantee local funding, completed workforce plans or agreed operational pathways. Panels will appreciate realistic awareness that some changes take years and depend on collaboration. Avoid saying every service must become virtual or community based. You can be ambitious and appropriately cautious at the same time.

15.3 Integrated care, neighbourhood services and partnership

Integrated care is about coordinating services and decisions around the needs of people and populations, rather than the convenience of organisational boundaries. For a hospital consultant, this means understanding the relationships among the provider, local community and primary care services, commissioners and other partners. Integrated care boards and local partnership structures have changed over time, so candidates should check the current arrangement in the region of their prospective employer rather than relying on a diagram learnt years ago.

Four points worth knowing: patients experience one journey even when several organisations are involved; shifting a task does not remove the need for expertise, resources and accountability; good integration needs reliable information and escalation; and patient participation and local population needs should influence the design. The test is whether the whole pathway works better, not simply whether the hospital carries out fewer appointments.

Consider a proposal to move follow-up of a long-term condition from hospital into the community. A consultant should ask which patients are suitable, what diagnostic access and training are needed, how the community team obtains specialist advice, how deterioration is identified, and who coordinates recalls and medication changes. The answer must also address data-sharing, safeguarding, accessibility and evaluation. A pilot with defined inclusion criteria and shared governance is more credible than an unqualified promise to “deliver care in the community.”

At interview, demonstrate that you can be a constructive partner even when priorities differ. The acute trust may want to reduce outpatient demand while community colleagues are facing their own workforce limits. Effective system leadership means recognising these constraints and seeking a clinically safe and mutually workable arrangement.

WORKED CASE

NHS strategy: understanding the 10 Year Health Plan without a lecture

What the panel is testing

The panel may want awareness of national direction, but the real distinction is between repeating slogans and translating strategy into clinically credible choices.

A plausible but weak answer

A weak answer lists the three shifts—hospital to community, analogue to digital, sickness to prevention—and stops. It may be accurate but tells the panel little about how the candidate thinks.

A stronger line of reasoning

A stronger answer identifies the shifts briefly and chooses one or two relevant implications: “In this specialty I would examine which follow-up activity genuinely requires a hospital visit and which patients might benefit from a more integrated community pathway. Digital tools could support triage and communication, but we would need to test accessibility, diagnostic safety and the effect on patients who struggle to use them. Prevention means addressing avoidable deterioration, not promising that every admission can be prevented. I would work with primary care, patients and the wider team, measure outcomes and remain realistic about workforce and funding.”

Why this is more convincing

This answer shows four anchor points: strategic direction, patient-centred opportunity, implementation constraints and a measurable local role. It avoids pretending that a national policy has already been fully delivered. The examples must be adapted to the specialty and Trust.

WORKED CASE

NHS strategy: understanding the 10 Year Health Plan without a lecture

The follow-up challenge

“Would you close clinics and move everything into the community?” No: decide according to complexity, patient preference, accessibility, safety, staffing, estate and evaluation. A strategic shift is not an instruction to move every service.

15.4 Think across boundaries without losing accountability

A patient pathway may cross acute, community, mental health, primary care, social care and voluntary-sector services. The consultant contribution is not to take responsibility for every organisation. It is to understand the interfaces, agree responsibilities with the relevant partners and make gaps visible when the pathway does not work.

When discussing a shift of care, ask what is moving: the location, the expertise, the workload, the funding or the accountability. Moving an appointment does not automatically move the capacity to manage deterioration. A useful proposal explains access to specialist advice, escalation, information sharing and ownership of follow-up, as well as convenience for patients.

Separate direction, delivery and local experience

The 10 Year Health Plan sets a national direction for England. Implementation depends on workforce, resources, commissioning, infrastructure and local circumstances. A statement of intent should not be presented as a service already available to patients. The Health Bill similarly describes intended structural change rather than proving that every function has already moved.

The NHS is not a single administrative system across the UK. When applying outside England, use the relevant nation's arrangements and terminology. The interview techniques in this handbook transfer well, but an England-specific commissioning structure or policy should not be presented as universal. For posts in the Republic of Ireland or elsewhere, use local appointment rules, organisational priorities and health-system sources.

FOUR-POINT BRIEF

The 10 Year Health Plan and the future direction of the NHS

- The three strategic shifts are hospital to community, analogue to digital, and sickness to prevention.
- Implementation requires joined-up pathways, a capable workforce, practical technology and changes in how services are organised.
- Patient benefit and reduced inequalities should be tested, not assumed; different specialties will need different delivery models.
- Change must be affordable, safe, evaluated and shaped with patients and the staff delivering it.

Consultant lens: Choose one shift that could genuinely change your specialty, describe a local opportunity, and name one barrier you would address.

FOUR-POINT BRIEF

Neighbourhood care, ICBs and partnership working

- Care pathways cross organisational boundaries, including acute hospitals, primary care, community teams and social care.
- Integrated care boards commission and plan services for their populations; providers retain responsibilities for service quality and delivery.
- Moving care closer to home may improve convenience but depends on capacity, clinical safety, coordination and access to diagnostics.
- Shared outcomes and communication are more useful than shifting activity or cost to another organisation.

Consultant lens: Explain which community and system partners your specialty relies on, and what smoother handovers would change for patients.

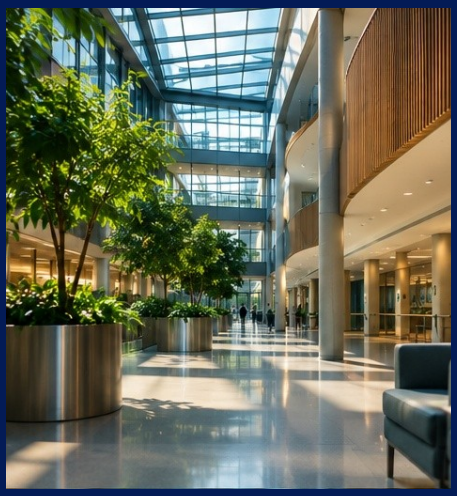
PUT IT INTO PRACTICE

Map a patient pathway

Identify the organisations and teams involved in one relevant pathway. Mark responsibilities, information transfers and likely gaps.

Self-check: Have you distinguished a national plan from local delivery?

16 Capacity, workforce and finance



Discuss operational pressures, prioritisation and resource choices without treating quality as an optional extra.

01 Demand and capacity
02 Workforce and culture
03 Finance and prioritisation

16.1 The planning framework, performance and productivity

The Medium Term Planning Framework 2026/27–2028/29 translates longer-term strategy into a multi-year planning and delivery context, including access, quality, productivity, workforce and system working. Its targets and implementation details may be updated; use the latest official version when preparing for an interview. You do not need to memorise every national number, but you should understand which metrics matter for your service.

Different specialties face different access measures. For some, referral-to-treatment waits and diagnostic capacity dominate; others are more influenced by emergency flow, cancer pathways, mental-health access or community outcomes. Ask which metrics the division reports, what the baseline is, whether performance is improving and what bottlenecks sit outside the immediate specialty.

Productivity means obtaining better outcomes and more effective care from available resources, not automatically shortening appointments or removing staffing. Useful examples include reducing duplication, avoiding unnecessary follow-ups, improving theatre utilisation, streamlining documentation and designing safer pathways. A consultant should be able to discuss value, cost, workforce and quality in the same answer.

Performance measures are signals, not the whole story

Many candidates memorise national targets but struggle to explain what a good consultant would do with performance information. Begin by identifying the measure and what it reflects: access, outcomes, quality, productivity, experience or workforce. Then ask whether performance is changing, what explains variation and whether a proposed improvement creates an unintended consequence. A high number of outpatient appointments, for example, can indicate productive capacity or unnecessary repeat reviews; the number alone does not establish quality.

A service improvement discussion should include the interaction between demand, capacity and pathway design. Rising waits can be driven by referrals, diagnostic bottlenecks, shortages, cancellation patterns, rework or poor coordination. Adding clinics may relieve immediate pressure but can conceal an inefficient process. Equally, changing referral thresholds without clinical governance risks delaying needed care. A consultant should examine data with frontline colleagues and managers, choose a safe intervention and measure several dimensions of improvement.

A miniature board-level test

Imagine the division meets its activity target but patients complain about access and staff sickness is rising. An unconvincing response celebrates the throughput figure. A thoughtful response asks what the activity measure misses: waiting-time distribution, cancellations, repeated appointments, clinical outcomes, patient experience and staff capacity. It investigates whether short-term productivity is being purchased at the

expense of a fragile workforce. This is the kind of balanced reasoning that moves an answer from policy recall to consultant-level judgement.

16.2 NHS finance without becoming a finance director

Panels do not normally expect a new consultant to run the Trust's finances, but they do expect an understanding that resources are constrained and choices have consequences. Know the difference between revenue (recurring income and expenditure) and capital (investment in assets and infrastructure), and recognise that saving staff time is not necessarily equivalent to an immediately realisable cash saving.

An effective business case identifies the problem, patient and organisational benefit, options considered, demand and capacity, staffing and non-pay requirements, risks, implementation costs, recurrent costs, measurable outcomes and how the change will be governed. When comparing options, consider quality and equity as well as price.

Talk about value, not merely cost-cutting

A good consultant asks whether an intervention offers appropriate outcomes for its costs, whether there is evidence of benefit, and whether it creates a burden elsewhere. Examples include reducing avoidable admissions, improving prescribing, preventing repeat tests, streamlining follow-up or making better use of clinical time. Avoid false precision about financial returns when data have not been established.

WORKED EXAMPLE

> “What would you do if the Trust asked you to make efficiency savings?” Explain that you would first understand the requirement and current cost drivers, protect essential safety and quality, engage the multidisciplinary team, examine unwarranted variation and test changes with balancing measures. Do not offer indiscriminate cuts that might increase downstream harm and expense.

The financial language worth knowing

Revenue expenditure includes ongoing pay and non-pay running costs. Capital expenditure concerns assets such as buildings and equipment. A new post typically creates recurrent costs, and a new machine may require staffing, maintenance, training and additional consumables. A saving in clinician time is valuable, but not automatically a cash-releasing saving: the released capacity might instead enable more patient contact, safer practice or reduced waiting. Candidates should distinguish these outcomes rather than promising a return on investment without evidence.

Service finance is inseparable from quality. A decision to reduce follow-up may lower appointment demand, but could worsen harm, complaints or emergency admissions if patients are discharged inappropriately. Conversely, an evidence-based change that avoids duplication may improve safety and free capacity. Consultants should be prepared to consider opportunity cost: using money, theatre time or staff for one proposal means it cannot simultaneously be used for another. The right comparison is between realistic alternatives, taking account of quality, patient benefit, workforce, equity, deliverability and affordability.

How to answer: “The Trust needs a significant saving. What would you do?”

Start by understanding the financial requirement, its timeframe and what flexibility exists. Establish baseline activity, cost drivers, quality outcomes and risks with divisional finance and operational colleagues. Involve the multidisciplinary team; they often know where avoidable steps, errors or delays occur. Consider unwarranted variation, procurement, medicines, scheduling, duplication and pathway design, without assuming that staffing reductions are the only answer. Test changes with agreed measures, including waiting times, safety, staff impact and patient experience. Escalate openly if the proposed saving would create unacceptable risk. A consultant contributes responsible options, not blanket promises to “work harder.”

Reading a business case through a consultant's eyes

What patient problem is it designed to solve? What alternatives were rejected and why? What baseline data and assumptions support the forecast? Who will undertake the work, including time for training? What are the recurrent and one-off costs? What governance, safety and equity risks exist? Which outcome measures will be reviewed at three, six and twelve months? A business case without these elements is a hope, not a robust implementation plan.

16.3 Workforce, culture and the consultant as a team leader

Workforce is not merely a question of how many doctors or nurses an organisation employs. Safe capacity depends on skill mix, supervision, retention, rostering, training, wellbeing and the way professionals work together. High sickness absence or turnover may indicate excessive workload, poor conditions or problems with culture, but the cause needs investigating. A consultant should understand how the service copes with absence, how it protects supervision and whether new ways of working are genuinely safe and sustainable.

Four points worth knowing: workforce pressure can threaten continuity and safety; retention and team culture matter alongside recruitment; delegation and new roles require clear competence, supervision and accountability; and service redesign must consider who will do the work, not just where the work moves. The practical question is how you would identify a bottleneck and support a safer, better-functioning team within real constraints.

Consider a service that relies on junior doctors routinely working beyond scheduled hours to complete discharge summaries. A weak answer praises their dedication. A thoughtful response checks whether clinical priorities are safe, explores workflow and task allocation, asks what work could be standardised or supported differently, involves colleagues and operations, and monitors both discharge quality and staff experience. It may conclude that extra staffing is needed, but it should reach that conclusion through evidence rather than assumption.

At interview, speak about culture in observable terms: listening, constructive feedback, fair rostering, reliable escalation, shared learning, supporting new staff and challenging bullying or discrimination. Good culture is not a substitute for performance expectations. It is one of the conditions that makes excellent performance possible.

16.4 Elective recovery, diagnostics and the problem of waiting

Elective waiting times are not simply an efficiency challenge. Delays can worsen illness, produce uncertainty and anxiety, reduce trust and exacerbate inequalities. Nevertheless, a consultant should avoid equating the number of appointments or procedures with success. Better access depends on matching demand with appropriate capacity and designing the whole pathway to avoid repeated steps that add little clinical value.

Four points worth knowing: first, understand the patient harm associated with delay and prioritise according to clinical need; second, examine the entire pathway from referral and diagnostics through treatment and follow-up; third, involve all professions who influence flow; fourth, monitor quality, reattendance and equity alongside volume. A new clinic may be useful, but not if diagnostics remain the limiting factor or patients are booked into avoidable follow-up.

For example, a consultant reviewing a long-waiting outpatient clinic might start by validating referrals, reviewing urgency and checking whether there is a pattern of duplicate investigations, unnecessary return appointments or incomplete referral information. They would work with the MDT, booking staff, diagnostic colleagues and managers to test appropriate improvements. They would be careful about changing clinical thresholds and would ensure patients can get rapid review if their condition changes.

Interview challenge: “Would you support increasing throughput by shortening all clinic appointments?” Do not give a reflexive yes or no. Explain the variation in clinical complexity, the need for safe triage, whether some straightforward encounters can appropriately be shorter, and what would be measured. The goal is more effective, equitable care rather than a blanket promise that activity always equals productivity.

16.5 Urgent care, patient flow and discharge

Crowding and delay in urgent and emergency care are whole-system problems. They can involve ambulance handover, emergency assessment, inpatient bed availability, diagnostic delay, specialty response, discharge processes, community services and social care. Although an individual specialty does not control the entire pathway, its consultants often influence early review, escalation, admission criteria, length of stay and safe discharge.

Four points worth knowing: delay can create clinical harm; flow requires cooperation across teams and organisations; safer alternatives to admission or prolonged stay are appropriate only for selected patients; and measures of success must include deterioration, return attendance, patient experience and staff workload. The danger of a narrow answer is that it treats discharge as an administrative target instead of a clinical decision with social and professional consequences.

Suppose the hospital is under pressure to discharge patients before midday. A consultant-level response would support reducing unnecessary delay while examining how clinical decisions, therapy input, pharmacy,

transport, family discussions and community support influence discharge. An earlier discharge that leads to unsafe readmission is not a genuine gain. Consider which changes lie within your specialty and where system partners must be involved.

At interview, connect this issue to the advertised post: if you are applying for an elective specialty, how could advice pathways, inpatient reviews, complication management or better follow-up reduce avoidable emergency demand? Showing that you understand your specialty's place in the wider hospital is more valuable than quoting emergency-care statistics from memory.

WORKED CASE

Pressure to increase clinic throughput

“Your service is under pressure to increase activity. A manager proposes shorter appointments and fewer follow-ups. How would you respond?”

What is being tested: Ability to balance access, patient outcomes, staff wellbeing, cost, and operational reality. The panel does not need a binary conflict between “management” and “clinical standards”.

Approach: Clarify the problem and current data: referral demand, case mix, wait times, appointment variation, missed appointments, follow-up patterns, staffing and outcomes. Discuss the proposal collaboratively and identify where a shorter appointment might be clinically appropriate and where it could introduce risk. Look at alternatives such as triage, patient-initiated follow-up where suitable, specialist nurse input, streamlining diagnostics, improved referral information or reducing duplication. Pilot the changes with clear safety and quality measures and review results across patient groups.

Potential challenge: “There is no extra funding.” Emphasise prioritisation, evidence of value and the possibility of redesigning existing work, while being honest about irreducible constraints. If safe activity cannot be delivered at the proposed pace, explain risks constructively and escalate through appropriate governance.

Practice question: What would you measure beyond number of appointments? Include patient experience, adverse events, reattendance, equity and staff workload.

WORKED CASE

Finance and quality: choosing rather than merely saving

What the panel is testing

This tests financial literacy, willingness to take responsibility and ability to avoid false economies. It is not an invitation to propose cuts without understanding harm.

A plausible but weak answer

A weak answer promises shorter appointments, fewer staff or a blanket reduction in follow-ups. These may reduce an input while creating reattendance, delayed diagnosis, staff burnout or risk elsewhere.

A stronger line of reasoning

A stronger response explains: “I would ask what the financial gap represents and which costs we can influence safely. I would examine unwarranted variation, duplication, stock or prescribing waste, clinic utilisation, avoidable admissions and rework. Any proposed change needs clinical and operational ownership, a baseline and an assessment of effects on quality, access, equity and staff. I would favour changes that remove low-value processes rather than simply transfer cost or risk. If the available savings are insufficient without unacceptable harm, I would say so clearly and escalate the trade-off.”

Why this is more convincing

Good financial answers use the language of opportunity cost. A saving in one budget is not necessarily a saving to the whole pathway. A business case should show assumptions, recurrent costs, workforce implications, benefits, risks and how benefits will be realised.

The follow-up challenge

“What if the finance director insists?” Show respect for organisational constraints, provide evidence and options, and escalate material patient-safety concerns through governance. The consultant must be a constructive partner, not an uncritical advocate of either spending or cuts.

16.6 Discuss finance through choices and consequences

A consultant is not expected to reproduce a finance director's technical analysis in every interview. You should, however, understand that a proposal has a cost, that resources have alternative uses and that apparent savings may not release money. Work with finance and operational colleagues rather than treating financial scrutiny as an obstacle to clinical work.

A reduction in staff time spent on an activity may create capacity without reducing payroll expenditure. A shorter admission may improve flow without immediately closing a ward or releasing its fixed costs. Conversely, a cheaper item may create more failures, delays or downstream activity. Explain what kind of benefit is being claimed and how it would be realised.

Distinguish demand, capacity and productivity

More activity is not always better productivity. Ask whether the activity is appropriate, whether the output benefits patients and what inputs it requires. Demand may grow because of population need, referral practice, repeated work or a change in the pathway. Capacity may be limited by people, rooms, equipment, diagnostics or another part of the service. Adding appointments will not necessarily address the true bottleneck.

When asked to improve productivity, begin with avoidable rework, unreliable processes, unwarranted variation and the appropriate use of skills. Consider whether the change transfers work elsewhere. Include staff experience, safety and equity among the checks on improvement; an apparent gain that depends on repeated unpaid effort is not a sustainable operating model.

WORKED EXAMPLE

The difference between capacity and cash

In an illustrative service, simplifying a task releases ten minutes of staff time per episode. That is not automatically a cash saving. The time may be fragmented, may be needed for work previously left undone or may allow additional activity without changing the staffing establishment.

A credible business case explains the number of episodes, the reliability of the time estimate and how the capacity would be used. It does not multiply minutes by an hourly rate and claim that the resulting figure will certainly leave the budget.

Respond to a savings target without an empty promise

Clarify the scale, timescale and scope of the request. Review the baseline, consider options with the multidisciplinary and management team, examine quality and equality effects, and distinguish recurrent from one-off benefits. Where a proposal creates an unacceptable safety risk, explain and escalate that risk rather than promising to deliver the target regardless.

The strongest contribution may include stopping low-value activity, improving purchasing or reducing avoidable duplication. It may also involve explaining why a proposed reduction is not deliverable safely. Your answer should show constructive participation, evidence and accountability rather than reflexive acceptance or blanket resistance.

FOUR-POINT BRIEF

Elective recovery, waiting lists and diagnostics

- Access is not just a waiting-list number: long waits can worsen outcomes, confidence and inequalities.
- Better pathways may involve referral triage, advice and guidance, diagnostics, theatre use and appropriate follow-up.
- Capacity and demand must be considered together; increased activity alone may not fix a poorly designed pathway.
- Track quality and balancing measures alongside throughput, so that faster care remains appropriate and safe.

Consultant lens: Pick a bottleneck in your patient pathway. Explain how you would analyse it with the MDT and measure improvement.

FOUR-POINT BRIEF

Urgent and emergency care, patient flow and discharge

- Emergency-department crowding and delayed care create patient-safety risks, not merely poor performance figures.
- Flow depends on the whole system: assessment, inpatient capacity, discharge processes, community provision and social care.
- Admission avoidance, same-day emergency care and earlier supported discharge may help when clinically appropriate.
- Improvement requires cross-specialty working and scrutiny of readmissions, deterioration, staff burden and patient experience.

Consultant lens: Even if your specialty is not emergency medicine, know how your service influences escalation, length of stay or safe discharge.

FOUR-POINT BRIEF

NHS finance, productivity and sustainable services

- The NHS must balance constrained resources with increasing demand and expectations about quality.
- Productivity means better value and outcomes from resources; it is not synonymous with indiscriminate cost-cutting.
- An effective business case considers patients, workforce, recurrent costs, alternatives, benefits and risks.
- Savings and efficiency claims should be evidenced and accompanied by balancing measures to detect unintended harm.

Consultant lens: Show that you understand the clinical consequences of financial decisions and can identify waste without compromising care.

FOUR-POINT BRIEF

Workforce pressures, culture and compassionate leadership

- Retention, wellbeing, supervision, skills and the experience of work affect the quality and continuity of care.
- Workforce redesign should use multidisciplinary skills responsibly, with appropriate training, boundaries and support.
- The 2026 NHS staff standards include areas such as line management, wellbeing, tackling racism, sexual safety and flexible working.
- An effective consultant helps create psychological safety, manages concerns fairly and addresses persistent performance problems.

Consultant lens: Offer a concrete example of how you would support a team, improve a difficult working culture or help a colleague succeed.

PUT IT INTO PRACTICE

Test a resource proposal

Choose a proposed efficiency or investment and identify the real bottleneck, full costs, benefits, dependencies and balancing measures.

Self-check: Have you separated activity, capacity, productivity and cash-releasing savings?

17
Quality, equity and population health



Connect quality with patient experience, equitable access, prevention and meaningful involvement.

01 Safety, effectiveness, experience
02 Equitable access
03 Prevention and involvement

17.1 Quality priorities in 2026: what is new?

The Quality Strategy for NHS-funded care in England, published in July 2026, places quality across the three connected domains of safety, effectiveness and experience. It emphasises consistent care, better outcomes and reduced inequalities. This is a useful modern organising principle when discussing clinical governance or assessing a service initiative.

The strategy also describes modern service frameworks for selected pathways. Check which current frameworks and specialty standards apply to your role. A national ambition, a locally commissioned pathway and an implemented clinical guideline are different things.

In your answers, integrate safety and improvement with patient experience, workforce reality and financial sustainability. Use current language, but never substitute an acronym for explanation.

Quality means more than the absence of an incident

The NHS quality framework brings together safety, effectiveness and experience. Safety considers whether people are protected from avoidable harm; effectiveness considers whether care is evidence-based and achieves appropriate outcomes; experience considers whether care is respectful, coordinated and responsive. These dimensions can pull in different directions. Faster discharge may appear efficient but can be unsafe if follow-up is unreliable. A guideline-compliant pathway may still be inaccessible to people with disabilities or language barriers. Patients' own priorities may differ from what clinicians initially assume.

Think about clinical governance as the system for noticing variation, acting on risk, improving outcomes and learning. It includes audit, evidence-based practice, patient feedback, incident learning, supervision and professional development, as well as clear responsibility and oversight. Improvement is iterative: data suggest a problem, analysis explores the cause, an intervention is tested, outcomes are reviewed and the service adapts. Saying “We would do an audit” is only the start. Explain what question the audit would answer and what action would follow.

From dashboard to decision

Suppose readmissions increase after a pathway redesign. A superficial explanation blames non-compliance. A better response checks whether definitions or case-mix changed, reviews individual journeys, involves patients and the team, investigates discharge information and access to support, and considers whether the redesign had unintended effects. The clinical leader is prepared to reconsider a favoured idea in light of unwelcome data. That willingness is a particularly persuasive marker of professional maturity.

A usable quality answer

A concise answer might say that you would examine any proposed change through patient safety, clinical effectiveness and patient experience, supported by staff experience and equity measures. Explain how local

baseline information, multidisciplinary review and patient involvement would lead to a small test of change. Close by stating what would convince you to continue, modify or abandon the intervention. This is far more valuable than reciting the names of multiple governance committees.

17.2 Improving equality, diversity, equity and inclusion at work

A consultant should explain what fairness looks like in the daily running of a team. "I treat everyone equally" is not enough when identical arrangements create different barriers. Nor is inclusion achieved merely by assembling a visibly diverse group. Ask who can participate, who receives opportunities, whose concerns are acted on and whether comparable standards are applied fairly.

Equality concerns fair treatment and opportunity. Diversity concerns the range of backgrounds, experience and perspectives. Equity recognises that different barriers may require different support. Inclusion means people are respected, can contribute and can influence work rather than simply being present. These concepts apply to staff and patients, but workplace experience and clinical access require different actions and measures.

Start with evidence and lived experience

Review recruitment, progression, training, workload allocation, flexible arrangements, complaints and staff feedback. Use relevant workforce race and disability equality indicators as starting points, not as proof of a particular cause. Identify where a gap appears and what information would help explain it. Examine the department as well as organisation-wide averages.

Listen to people affected and to staff networks without treating one individual as a spokesperson for a whole group. Experience varies within categories and across intersecting circumstances. Use confidential channels, protect small numbers and collect sensitive information only with a clear purpose and appropriate governance. A colleague should not have to disclose a diagnosis in a team meeting to obtain support.

Make recruitment and appointment decisions fair

Use criteria linked to the role, consistent questions and clear evidence-based assessment. Challenge vague language such as "not our type" when it substitutes familiarity for competence. Consider whether informal sponsorship, inaccessible arrangements or assumptions about career paths affect who can demonstrate ability.

Support appropriate adjustments and accessible information through the relevant recruitment arrangements. Review shortlisting and appointment patterns without jumping from a difference in rates to a single assumed cause. Examine criteria, process and experience with appropriate expertise. Decisions should be defensible, not based on stereotypes about identity or background.

Make opportunities and workload transparent

Inequalities can develop after appointment. Ask who receives teaching, research, improvement, acting-up, leadership and development opportunities. Make opportunities visible and use transparent criteria. Does a part-time colleague, locally employed doctor or international recruit have the same practical access as someone embedded in informal networks?

Notice less visible work: minute-taking, emotional support, routine administration, covering gaps and organising events. Avoid repeatedly giving the same people these tasks while others receive career-enhancing responsibilities. Discuss allocations openly, acknowledge contributions and consider whether existing workload makes a development opportunity genuinely accessible.

Make everyday participation accessible

Circulate agendas and important information in advance, explain unfamiliar abbreviations and prevent repeated interruption. Invite perspectives without compelling someone to speak publicly about a sensitive experience. Provide alternative routes to contribute. Credit the originator of an idea rather than only the senior person who repeats it.

Consider meeting times, location, remote access and document accessibility. Ask what helps colleagues participate and use agreed processes for adjustments. Predictable instructions, written summaries or a different meeting arrangement may remove a barrier while maintaining the same professional expectations. Do not assume identical needs from a shared diagnosis or background.

Support disability, neurodiversity and different circumstances

Start with the individual's needs and agree practical support, who will arrange it and when it will be reviewed. With appropriate confidentiality, involve occupational health or relevant support services where useful. Avoid requiring a colleague to repeatedly justify an established arrangement or negotiate every barrier alone.

Caring responsibilities, religious observance, recovery from illness and other circumstances require thoughtful planning within service constraints. Explain how requests are considered and avoid treating flexibility as a proxy for commitment. Maintaining standards and adapting how someone meets them are compatible. Check the applicable local and national framework rather than offering improvised legal assurances.

Respond to discrimination and exclusion

Address immediate harm, support the affected person and state the professional expectation. A calm intervention might be: "That comment is not acceptable; let us focus on the issue respectfully." Choose a safe, effective response and do not make the affected colleague responsible for confronting the behaviour.

Follow up privately, ask what support is needed and explain reporting options and confidentiality limits. Document and escalate according to severity, recurrence and policy. A serious allegation is not resolved by a generic reminder to be kind. If a patient behaves abusively towards a colleague, support staff and manage care and safety appropriately rather than treating discrimination as a preference that must automatically be accommodated.

IN PRACTICE

The same person receives every opportunity

A project is routinely offered to the colleague most visible in informal conversations. A part-time consultant and several locally employed doctors only hear about opportunities after decisions have been made.

Rather than assuming a lack of ambition, make future opportunities explicit, define the skills required and invite expressions of interest. Provide supported development and review who receives meaningful responsibility. A token invitation after ownership is decided does not create equitable access.

Use mentoring and sponsorship without new favouritism

Mentoring can help colleagues understand options; sponsorship involves actively opening opportunities and advocating for their contribution. Both can help where informal networks are uneven. Make access transparent, match support to need and review whether it produces real development rather than another programme with little effect.

Give constructive feedback fairly. Do not withhold it because the conversation feels difficult, and do not equate an unfamiliar communication style with lack of ability. Explain expectations, provide support and use consistent processes. Inclusion is compatible with proportionate performance management and does not require avoiding accountability.

Connect inclusion with patient access and outcomes

A team that hears different perspectives may recognise overlooked barriers. Nevertheless, staff diversity does not automatically guarantee equitable care. Examine referral, waiting, attendance, treatment and outcome patterns. Ask patients about interpretation, transport, disability access, digital systems, health literacy and trust in the service.

Involve patients and carers early enough to influence design, with arrangements that make participation feasible. Test accessible information, interpreter access, alternative booking routes or adjusted scheduling according to the barrier identified. An improvement in the overall average can conceal worse access for a smaller group. Consider benefits, practical constraints and unintended effects rather than promising universal improvement.

Measure what changes

For development opportunities, examine who applies, participates and gains responsibility. For adjustments, ask whether a barrier is actually removed without repeated renegotiation. For discriminatory behaviour, review whether concerns were acted on and retaliation prevented. For workload, ask whether burdens and opportunities are allocated on a defensible basis.

Combine quantitative patterns with qualitative experience. A small department may not have enough data for meaningful subgroup percentages; confidential conversations and process reviews can still identify problems.

Avoid publishing identifiable details or drawing conclusions from unstable numbers. Obtain appropriate analytical and equality expertise when needed.

Avoid common interview traps

Do not rely on listing protected characteristics, attending mandatory training or claiming never to have witnessed discrimination. Do not assume whole communities have identical preferences or expect minority colleagues to undertake all inclusion work. Acknowledge blind spots and explain how you seek feedback and examine decisions.

Do not promise instant equality of outcomes or assume every disparity proves discrimination. Equally, imperfect data are not a reason to ignore a credible concern. Understand, act, measure and adjust. Where legal or employment matters arise, work within the relevant jurisdiction and obtain appropriate advice.

ILLUSTRATIVE ANSWER

How would you improve EEDI in this department?

"I would consider both staff experience and patient care rather than make this a separate awareness exercise. For the team, I would examine recruitment, workload and access to development, listen to colleagues whose experience differs from mine and agree practical priorities.

"I would make opportunities transparent, ensure meetings and information are accessible, support appropriate adjustments and challenge discrimination. I would involve relevant staff networks and organisational expertise without expecting affected colleagues to solve the problem alone.

"For patients, I would investigate gaps in access and outcomes with those affected, then test changes that address the actual barrier. I would monitor whether participation and experience improve, including for smaller groups, rather than simply count training sessions."

PUT IT INTO PRACTICE

Prepare two specific examples

Prepare one genuine example involving colleagues and another involving patient access or experience. Explain the barrier, how you understood it, what changed and the evidence of its effect. Include what you would do differently now.

A modest, specific improvement is stronger than claiming to have created an inclusive department. Make your own contribution clear and acknowledge the colleagues, patients and partners involved.

17.3 Prevention, population health and reducing inequality

Prevention is an important national ambition, but it is easily reduced to vague slogans. Primary prevention seeks to avoid the onset of illness; secondary prevention identifies problems earlier; tertiary prevention reduces the effects of established disease. The relevance differs by specialty. A consultant can contribute through risk-factor interventions, vaccination pathways where applicable, earlier recognition of deterioration, medication optimisation, safer follow-up and better communication across services.

Four points worth knowing: prevention can improve outcomes and reduce avoidable harm; opportunities should be evidence-based and specialty-specific; the people most likely to benefit may be the hardest to reach through conventional pathways; and the benefits, costs and timescales must be assessed realistically. A prevention initiative should not be described as immediately cost-saving unless supported by a credible economic evaluation.

Imagine patients from a deprived neighbourhood are more likely to present with complications of a chronic condition. An effective consultant response investigates whether the pattern reflects prevalence, access, referral delays, communication, continuity or other factors. It involves patients and local services, selects an intervention that addresses the actual barrier, and monitors clinical outcome and uptake rather than publicity alone. The consultant's role is to bring clinical insight, evidence and practical partnership to a population-level problem.

Panels sometimes ask, “What could your department do to support prevention?” Answer with one or two plausible interventions tied to local need, not a list of national campaigns. Explain who would need to collaborate, how the intervention could change the pathway and what would count as success.

WORKED CASE

An equity gap in service access

"We have noticed lower attendance and poorer outcomes in a local population group. What would you do as a consultant?"

What is being tested: EEDI as applied to patient care, analytical caution, co-production and measurable action. The panel wants to see more than generic commitments to respect.

Approach: First validate the data and distinguish differences in underlying need from potentially avoidable inequalities. Explore referral criteria, appointment availability, interpretation, travel, accessibility, health literacy, digital design, trust in services and patient experience. Engage patients and communities, local clinicians and relevant partners to understand the barriers. Test changes designed around identified causes, such as accessible communication or more appropriate appointment options, and measure whether access and outcomes improve. Review for unintended impacts on other groups.

Potential challenge: "Would you treat that group differently?" Explain that equity means responding fairly to different barriers and needs; it does not mean making assumptions about an individual's preferences or lowering clinical standards.

Reflection: In your own specialty, what is one plausible inequality you could investigate using local data, and what might be a meaningful measure of progress?

WORKED CASE

EEDI and equitable access: fairness is not sameness

What the panel is testing

This tests whether the candidate can distinguish consistent standards from the different support patients may need to achieve safe and fair access.

A plausible but weak answer

A weak answer says, "Yes, I am colour-blind and treat everyone identically." The intention may be positive, but identical processes can disadvantage patients facing language barriers, disability, digital exclusion or unequal access.

A stronger line of reasoning

A stronger answer is: "Every patient deserves the same respect and clinical standards, but fairness does not always mean an identical pathway. I would review whether particular groups have poorer access, later diagnoses, lower uptake or worse outcomes. Depending on the evidence, appropriate adjustments could include interpretation, accessible information, different appointment routes or outreach. I would work with patients, colleagues and data teams to assess whether changes narrow the gap without compromising care."

Why this is more convincing

For a consultant, EEDI also concerns fair recruitment, supervision, allocation of opportunity, respectful behaviour and acting on discrimination. Avoid turning it into a generic declaration of values: use a concrete patient or staff example and an observable action.

The follow-up challenge

"Would targeted support be unfair?" Explain that proportionate support aims to remove barriers, guided by evidence and relevant equality duties. Test whether the intervention works rather than assuming good intentions guarantee equity.

17.4 Make involvement and equity practical

A service can improve its average performance while becoming harder to use for a particular group. Ask who is represented in the data, who is missing and whether the same pathway has different effects on different patients. An overall attendance rate does not explain whether language, disability, cost of travel, caring responsibilities or digital access create avoidable barriers.

Do not assume the reason for a difference. Examine the pathway and listen to people affected. A missed appointment may indicate a communication problem, an inaccessible booking process or circumstances that the service has not understood. The response should be based on evidence rather than a stereotype about a community.

Involve people early enough to influence the design

Consultation after the important decisions have been made is not the same as designing a service with people. Decide which decisions are open, whose experience is needed and how participants can contribute meaningfully. Offer accessible information and practical arrangements; be clear about constraints and close the loop by explaining what changed because of their involvement.

A patient group is not automatically representative of every service user. Consider who finds participation difficult, whether carers need a separate voice and how to hear from people who no longer engage with the service. Do not promise that every suggestion will be adopted. Explain how competing views will be considered and decisions communicated.

IN PRACTICE

An efficient digital pathway with an access gap

A department proposes online-only booking. Early feedback is positive, but patients with limited digital access are underrepresented. The team tests assisted booking and a non-digital route, checks who completes the process and asks patients about the remaining barriers.

The learning is not that digital care should be rejected. It is that a convenient default needs accessible alternatives and monitoring, otherwise the service may measure satisfaction only among the people able to enter it.

Connect prevention with the actual role

Prevention is broader than giving lifestyle advice. It can include earlier recognition of deterioration, reducing avoidable complications, reliable follow-up and collaboration around risk factors. Choose contributions relevant to your specialty and within the scope of the role. Recognise social and practical constraints rather than implying that unequal outcomes are simply the result of individual choices.

Core20PLUS5 is one England-specific approach to focusing action on healthcare inequalities. Understand its purpose and check the relevant adult or children and young people's framework, but do not force every specialty problem into a memorised list. The useful interview contribution is an explanation of the local gap, the people affected, a practical response and how you would evaluate it.

FOUR-POINT BRIEF

Quality, clinical effectiveness and patient experience

- The 2026 national Quality Strategy treats safety, clinical effectiveness and patient experience as inseparable domains.
- High-quality care means reliably delivering evidence-based outcomes that matter to patients.
- Variation may identify opportunities for improvement, but interpretation requires case mix, local context and data quality.
- Patients and staff need to help define, deliver and assess improvements, including effects on inequalities.

Consultant lens: Choose a realistic service improvement and describe one outcome, one experience measure and one safety measure.

FOUR-POINT BRIEF

Health inequalities, EEDI and equitable access

- Different communities may experience unequal access, experience and outcomes for reasons beyond clinical need.
- Barriers can include deprivation, disability, language, travel, culture, digital exclusion and service design.
- Equal treatment is not always equitable care; identify evidence of barriers before choosing a response.
- Improvement requires listening to affected communities and measuring whether the gap actually narrows.

Consultant lens: Identify one plausible inequality in your specialty and propose a change that could be co-designed and evaluated.

FOUR-POINT BRIEF

Prevention and population health

- Prevention spans primary prevention, early identification, secondary prevention and reducing avoidable complications.
- The best intervention depends on disease burden, patient population, evidence, equity and available resources.
- Clinical services can contribute through earlier detection, risk-factor management, safety-netting and continuity.
- Prevention benefits need realistic timescales and measures; promises of immediate savings are often not credible.

Consultant lens: Identify one prevention opportunity in your specialty and say how the service could support it without losing sight of current demand.

FOUR-POINT BRIEF

Transparency, accountability and public trust

- Patients are entitled to honest communication, reliable information and professional behaviour when care goes wrong.
- Clinical governance requires clear responsibility, learning, quality assurance and use of feedback and data.
- Speaking up and responding constructively to concerns are essential for a healthy patient-safety culture.
- Greater transparency is useful when information is understandable, accurate and used for learning rather than blame.

Consultant lens: Show how you would respond transparently to a difficult outcome while supporting patients, staff and improvement.

PUT IT INTO PRACTICE

Look for who is missing

Take one service measure or redesign and ask which patients are absent from the data or conversation. Plan how to understand the gap.

Self-check: Does the proposal improve access and experience beyond the average patient?

18
Digital transformation and innovation



Evaluate technology through patient benefit, implementation, inclusion and clinical accountability.

01 Problem and evidence
02 Safety and information
03 Implementation and review

18.1 Artificial intelligence and digital transformation

AI is an important NHS topic because it may change administrative work, diagnostics, decision support and patient access. A consultant-level response should combine curiosity about benefit with discipline about safety and governance. Ask what problem the tool solves, how performance is validated in the intended population, who remains accountable, how errors are detected, whether there are biases, and how privacy and information governance are protected.

Examples might include ambient documentation tools, automated triage support, imaging analysis or predictive analytics. They differ substantially in risk, evidence, regulatory requirements and the role of clinician oversight. Not every tool labelled “AI” is safe or effective for routine use; nor should every proposal be rejected on principle. Local procurement, cyber-security, clinical safety, data protection and professional guidance are relevant.

Six questions before adopting a digital tool

What clinical or operational problem are we solving, and what is the baseline?

What credible evidence supports benefit and safety in our population and workflow?

Who retains responsibility for reviewing, correcting and acting on outputs?

Could the technology worsen inequalities or create new risks?

What are the cost, workforce, information-governance and training implications?

How will we monitor real-world performance and withdraw or adapt the tool if needed?

Interview tip: Explain one opportunity relevant to your specialty and one serious limitation. That demonstrates judgement more effectively than saying AI will transform everything or that it has no place in healthcare.

AI is a clinical governance question, not just a technology question

The term artificial intelligence covers very different tools: administrative assistance, image interpretation, prediction, communication and clinical decision support. Their risks are not equivalent. A consultant should first define the clinical or operational problem, then ask whether the technology has evidence of benefit over the current process in the intended population and workflow. A striking demonstration is not the same as validation in routine practice. Local implementation may introduce unexpected burdens if integration with existing systems is poor.

For clinical applications, examine who is accountable for reviewing the output, what data are used, how information is protected, how bias or performance differences across populations are assessed, how failure is detected and what happens when staff disagree with the tool. Digital literacy and staff training are essential. Consider data governance and any applicable regulatory and clinical safety standards; these differ according to the product and intended use. Clinicians should not claim that a tool is safe simply because it has been procured.

Scenario: the tool improves speed but makes a consequential mistake

Imagine an AI-supported triage application appears to reduce administrative burden but is found to deprioritise some urgent referrals. The appropriate response begins with protecting patients and establishing whether a current safety risk requires immediate restriction or suspension. Engage clinical safety, information governance, digital and operational leads. Examine which cases were affected, how the problem arose and how patients should be contacted or re-triaged. Communicate openly through appropriate processes. Then reconsider the validation, monitoring and human oversight arrangements. The lessons are not “never use AI” or “AI will solve waiting lists,” but evidence, transparency and accountable implementation.

Interview response that shows balance

“I am positive about digital tools when they address a real clinical problem and are evaluated properly. I would want to see evidence in our patient population, understand what clinicians remain responsible for and ensure that safety, equity, staff training and information governance are built into the pathway. I would start with a measured pilot and be prepared to change course if the evidence did not support wider adoption.” This is a reasoned position, not an answer to memorise word for word.

WORKED CASE

Introducing an AI-supported tool

“A technology company offers a system that promises to reduce reporting time by 40%. Would you adopt it?”

What is being tested: Proportionate optimism, patient safety, financial literacy, information governance and professional accountability.

Approach: Identify the operational or clinical problem and seek independent evidence for the proposed benefit. Understand intended use, regulation, validation in the local population, false positives and negatives, and how outputs are reviewed. Involve clinical safety, digital, information-governance, patient and operational stakeholders. Consider cybersecurity, bias, accessibility, costs, workflow change, maintenance and staff training. If appropriate, design a monitored pilot with predefined success and withdrawal criteria before scaling.

Potential challenge: “But the Trust needs savings now.” State that timely evaluation is important, while a fast introduction that creates error, rework or inequity may be a false economy. Discuss a proportionate pilot rather than indefinite delay.

Common pitfall: Describing AI as either inherently transformative or inherently unsafe. The evidence, use case and safeguards are what matter.

WORKED CASE

AI and innovation: enthusiasm with clinical accountability

What the panel is testing

The panel is assessing risk awareness and implementation judgement, not whether the candidate knows every technical term.

A plausible but weak answer

A weak answer is either “Yes, because innovation is essential” or “No, AI is unsafe.” Both bypass the important questions: purpose, evidence, suitability, regulation, governance and consequences.

A stronger line of reasoning

A stronger response is: “I would define the clinical problem first and examine the evidence behind the claim, including the population in which it was tested. We would need information-governance, procurement, clinical-safety and regulatory review as relevant, together with bias and accessibility assessment. I would clarify who remains accountable for decisions, how errors are detected, the human-oversight model and the fallback when the system fails. I would favour a monitored pilot with agreed outcomes, escalation arrangements and a decision point before wider adoption.”

WORKED CASE

AI and innovation: enthusiasm with clinical accountability

Why this is more convincing

Good innovation balances CHANGE with PEOPLE and RESULT: staff need training and trust, patients need transparency and safeguards, and measured benefits must include quality and unintended harms as well as speed.

The follow-up challenge

“What if the tool saves time but misses more disease in one demographic group?” Pause or restrict use as appropriate, assess immediate patient risk and investigate the subgroup performance. Productivity cannot justify avoidable inequity or unsafe care.

18.2 Evaluate innovation from problem to implementation

Start with the service problem. A new application, algorithm or device is not itself an outcome. Ask what it would improve, for whom and compared with what alternative. A useful tool can still fail if it adds duplicate work, does not integrate with existing systems or creates an unclear responsibility for acting on its output.

Consider the evidence in the population and setting where it will be used. A performance figure from a development dataset does not settle how the tool will behave in local practice. Ask about errors, different patient groups, user training, workflow and monitoring after implementation. Be ready to say that a promising product needs further evaluation before adoption.

Make human oversight specific

"A clinician will check it" is not a complete safety arrangement. Who will check, at what stage, with what information and with enough time to detect what kinds of error? If the tool's output looks plausible, how will staff recognise when it is wrong? What happens during downtime, and who can suspend use?

For health IT, clinical safety requirements include responsibilities for manufacturers and for organisations deploying and using systems. Know that specialist clinical safety and information-governance input is needed; do not imply that a consultant can sign off a system alone because it appears useful. Check the applicable DCB0129 and DCB0160 arrangements and current guidance.

Handle data lawfully and transparently

Do not upload identifiable patient or staff information into an unapproved tool. Organisational approval, appropriate data arrangements and clear responsibilities matter, including for apparently simple transcription or summarisation tasks. Explain how you would involve information-governance and clinical-safety colleagues rather than treating a supplier's assurances as sufficient.

IN PRACTICE

The fluent summary that omits the crucial fact

An AI-generated summary is readable and saves drafting time, but omits a qualification that changes the meaning of the plan. The consultant checks the source information, corrects the record and reports the problem through the relevant process. The team reviews whether its checking arrangements are capable of detecting similar omissions.

The important interview point is not whether the technology is good or bad in the abstract. It is whether the service has a credible route for identifying, containing and learning from failure.

Judge success after adoption

Monitor benefit, error, workload, access and unintended effects. A reduction in one task may create a new checking burden. A tool may perform differently as the population or workflow changes. Agree ownership, review points and conditions for modifying or withdrawing the system. Innovation requires continuing judgement, not a single enthusiastic launch.

FOUR-POINT BRIEF

Digital transformation and artificial intelligence

- Digital tools and AI may improve access, documentation, diagnostics and operational efficiency, but benefit is context-specific.
- Evaluation should consider clinical performance, bias, data protection, cyber-security and potential exclusion.
- Professional accountability, human oversight, clear escalation routes and staff training remain essential.
- Adoption requires monitoring in real-world practice and a plan to adapt or stop a tool that performs poorly.

Consultant lens: Name one opportunity relevant to your specialty, one important risk and how you would evaluate the tool before wider use.

PUT IT INTO PRACTICE

Appraise one digital idea

Define the problem, comparator, evidence, safety arrangements, data requirements, implementation burden and review criteria.

Self-check: Is human oversight a real process or just a reassuring phrase?

19
Rehearsal, interview day and learning afterwards



Practise adaptively, use feedback intelligently and manage the practical demands of the interview.

01 Targeted rehearsal
02 Unexpected questions
03 Interview-day preparation

19.1 The seven-day preparation sprint

You cannot predict every question, but you can improve the clarity and adaptability of your answers dramatically in one focused week. The schedule below assumes you already have a relevant professional background and have attended or are attending an ISC Medical course. Adjust it to the time you actually have; preparation should be deliberate rather than exhausting.

Day	Main task	Deliverable
1	Read job description, person specification and organisational strategy	One-page role-fit summary
2	Map panel and local service priorities	Trust/service fact sheet; visit questions
3	Build personal and leadership evidence bank	Six adaptable experience stories
4	Revise governance, safety and NHS issues relevant to your post	Three current-issue talking points
5	Prepare introduction, motivation and presentation	Timed versions and clear main message
6	Simulate a mixed panel; practise follow-up questions	Structured feedback and improvement priorities
7	Light review, technical/logistical check and rest	Short prompt sheet, not a new script

19.2 A 20-minute mock-panel practice plan

Ask two or three colleagues to play different panel perspectives: one clinically focused, one interested in service delivery, and one focused on people or organisational values. Give each person a short list of questions and a simple scoring guide. Ask them to follow up where you make an unsupported claim, skip the question or rely on a slogan.

Minutes 0–3: introduction and motivation. 3–8: leadership or conflict example. 8–13: service improvement or governance scenario. 13–18: an NHS issue and a challenging follow-up. 18–20: candidate questions and closing. Afterwards, ask the observers for one strength, one concern and one specific recommendation each. Review the answers for relevance, evidence, judgement and the impression of working with you.

A constructive feedback form

Dimension	Score 1–5	One observable example
Answers the question asked	____	_____
Clear structure and signposting	____	_____
Personal contribution and evidence	____	_____
Consultant-level judgement	____	_____
Warmth, credibility and collaboration	____	_____
Local knowledge and future fit	____	_____

The numbers are for coaching reflection only, not a prediction of an employer's mark or likelihood of appointment.

Six challenging follow-up questions to practise

“What would you do if the manager disagreed with your clinical plan?” Distinguish legitimate constraints from unacceptable risks; find common objectives and support your position with evidence. “What if the data disproved your preferred solution?” Show willingness to adjust or stop. “What if a colleague claimed you took credit for their work?” Acknowledge shared contribution and clarify your own actions without defensiveness. “Why not simply spend more money?” Discuss opportunity cost and alternative designs, without denying the need for investment when justified. “What does this mean for patients who cannot use digital tools?” Identify equity risks and alternative access. “You have only six months - what is the first priority?” Choose a feasible step and explain why.

The quality of rehearsal depends on the follow-up, not the first answer. Ask the person acting as a panel member to challenge an assumption, demand a measure or identify a stakeholder you overlooked. Work on being curious rather than defensive. When confronted by an unexpected detail, make your reasoning visible and state what further information would affect the decision.

19.3 Your final 24-hour checklist

☐ I know the role, the person specification and the three messages I want the panel to retain.

☐ I can explain why this specific organisation and department appeal to me.

☐ I have six genuine evidence stories and know the outcomes and lessons.

☐ I understand the panel's composition or the likely perspectives represented.

☐ I have reviewed the current NHS priorities relevant to this specialty and locality.

☐ I have prepared one balanced answer about AI, equity and system working.

☐ I have checked the presentation instructions and rehearsed within time.

☐ I have checked travel or technology, identification and interview logistics.

☐ I have prepared thoughtful questions about the job and service.

☐ I have stopped rewriting scripts and allowed time to rest.

Questions worth asking at the end

An end-of-interview question should help you understand the post, not rescue a weak answer. Good questions might concern the department's priorities for the successful candidate, how it measures quality and

improvement, relationships with community services, the support available for service development or how job plans and educational responsibilities are agreed. Do not ask for facts already clearly answered in the recruitment pack.

WORKED CASE

Answering a question you cannot fully answer

What is being tested: Awareness, reasoning under uncertainty, honesty and adaptability. Some policy questions contain a specific term that you may not have read in depth. The panel is not asking you to bluff.

Approach: If you recognise the framework, state the principle correctly and connect it to your specialty and service. If you are uncertain, distinguish what you know from what you would verify: “I have not yet read that framework in sufficient detail to quote its recommendations accurately. My understanding of the wider quality agenda is that it aims to reduce variation and improve evidence-based outcomes. I would check the specific standards, compare them with our local pathway and involve the relevant clinical and operational teams.” Avoid a long, confident account of a document you have never seen.

Potential challenge: “Should a consultant know every new national policy?” Acknowledge responsibility to maintain awareness of developments relevant to one's practice, and describe how you monitor guidance, appraise changes and implement them safely. Do not imply that professional competence means perfect recall.

Practice: Ask a colleague to introduce an unfamiliar but plausible health-policy term. Your objective is to remain useful and accurate without pretending expertise.

WORKED CASE

A vague answer versus a convincing one

Unhelpful version: “I am a good leader who communicates well. I ran an audit and everyone was very happy. I have always been respected by the team and I would bring that approach to your Trust.” The answer offers claims but almost no assessable evidence. There is no clear task, choice, impact or learning.

Better answer design: Begin with a concrete problem and reason for acting. Briefly establish your responsibility. Explain how you involved others, what difficult decision you made, how you responded to resistance and what changed. Report an outcome honestly, including an available measurement or feedback. End with a lesson that would transfer to the consultant role. Do not add fabricated percentages merely to sound impressive.

What the panel can now assess: Collaboration, initiative, problem-solving, proportionality, delivery, reflection and relevance. Your tone and pace matter, but they cannot replace that evidence.

A self-scoring challenge

Score your own example from 1 to 5 against each of the following: specificity, personal action, impact, reflection, relevance to this post. Then ask a colleague to score the same spoken answer without seeing your notes. Differences in score often reveal where your message is not coming through.

19.4 Ten traps that weaken otherwise good candidates

Answering the prepared question rather than the question asked. Listen for its exact purpose and adjust.

Giving a list instead of a judgement. Explain which option you would prioritise and why.

Leading with a long disclaimer. Make your useful point early, then qualify appropriately.

Being vague about personal contribution. Distinguish what you did from what your team did.

Treating a colleague as the problem rather than understanding the situation. Be fair, curious and proportionate.

Claiming to have solved an issue without measures. State observable outcomes and limitations.

Sounding like a policy manual. Connect the policy to patients, colleagues and your local service.

Treating confidence as volume or certainty. Confidence includes acknowledging uncertainty and listening.

Trying to demonstrate every competency in every answer. Choose what is relevant and stop.

Over-rehearsing to the point of rigidity. Prepare evidence and reasoning; allow room for a real conversation.

19.5 How to read an example answer

The following examples are not scripts or model answers. Their purpose is to make the thinking visible. Each case begins with what the panel is testing, explains a sound approach, and contrasts a superficially attractive answer with a more mature one. Replace every example with your own experience and adapt it to the advertised service. An answer that is correct in one context can be unsafe or misleading in another.

A useful self-assessment asks five questions. Did I answer the question early? Did I distinguish facts from assumptions? Did I make a defensible choice and explain my reasoning? Did I attend to the people affected? Did I identify evidence of success and what I would do next? A persuasive answer usually shows judgement without pretending that every problem has an effortless solution.

19.6 Use the cases to build your own answers

Choose three of the worked cases. For each, write the one-sentence answer you would give first, the three ideas you would prioritise, a specific example from your experience and one important risk or limitation. Practise the answer aloud in 90 seconds, then ask a colleague to challenge an assumption. Your aim is not to reproduce the language above but to explain a decision as a safe, reflective consultant would.

In the final rehearsal, ask: Would the panel hear something true about me? What evidence could I offer if pressed? Have I been fair to colleagues and patients? Have I explained both the opportunity and the downside? Have I identified what success would look like?

19.7 Rehearse in a way that exposes weaknesses

Silent reading is not a reliable test of an interview answer. Speak aloud, record a sample and ask a colleague to assess what they actually heard. Begin with an uninterrupted answer, then add follow-up questions and changes of emphasis. The aim is to retain the substance when the conversation does not follow your preferred script.

Separate feedback about content, reasoning and delivery. "You sounded confident" does not establish that the answer was relevant. "You need more detail" may mean that your personal action was unclear rather than that the answer should be longer. Ask the listener to identify the exact missing evidence and practise only that element before repeating the whole answer.

Use follow-up questions to test ownership

Ask: why did you choose that option; what did you personally do; what did the other person think; how do you know it helped; what remained unresolved; and what would you change now? An example that cannot withstand these questions may need better analysis or may not be the right example. Do not repair it by inventing detail.

Practise recovery, not perfection

Deliberately practise losing your place, receiving an unexpected question or being told that time is short. Pause, identify the main point and continue. A brief correction of an inaccurate statement is preferable to defending it because it appeared in your preparation notes.

After a mock interview, select two or three changes rather than rewriting every answer. For example: shorten context, clarify personal actions and make reflections more specific. Repeat the exercise to see whether those changes are audible. Preparation becomes more effective when feedback produces a particular behaviour rather than a general intention to be better.

20
Your preparation workbook



Build a personal evidence bank, practise probing questions and assemble a concise final interview brief.

01 Evidence and values
02 NHS and presentation briefs
03 Practice questions and worksheets

20.1 Build a working preparation pack

Use the following pages to organise your own material. They are deliberately compact: a completed pack should help you retrieve the right evidence quickly, not become a second handbook. Keep patient and colleague information anonymous and do not include confidential documents merely to make an example easier to remember.

Start with the role and employer, then build the evidence bank, values matrix, NHS topic briefs and presentation plan. Finish with a one-page summary of the main contribution you want the panel to understand. Review the pack against the actual job description and your latest information from the employer.

Evidence-bank rules

Use real examples with a clear personal contribution. Record the outcome accurately, including limitations. Identify two or three meaningful themes and the skills each demonstrates. Include at least one example that did not go entirely well and one in which you changed your view after listening. An example may support several questions, but do not force it into a question it does not answer.

A final test before the interview

Ask someone unfamiliar with your specialty to listen to a leadership or conflict example. Can they explain the problem, what you did and what it shows about you? If not, remove unnecessary technical context and make the decisions clearer. Then ask a specialist colleague to probe the same example for accuracy and depth. You need both clarity and substance.

20.2 Your two-page personal interview brief

This final exercise draws the whole book together. The best version is only two pages long, written in your own words. It should be useful enough to read before the interview and concise enough not to become another script.

My preparation question	The answer I need to know
What are the Trust's and service's three main priorities?	_____
Why do I want this particular post?	_____
What three qualities do I most want remembered?	_____
Which achievement demonstrates my greatest relevant impact?	_____
What is my strongest leadership/change example?	_____
What example best shows reflection and growth?	_____
Which governance or patient safety example will I use?	_____
What would be a sensible first-year contribution?	_____
Which current NHS development is most relevant locally?	_____
What two questions genuinely matter to me?	_____

Final rehearsal: Ask a trusted colleague to read only your two-page brief and describe the consultant they expect to meet. If their description does not match the person you want to present, revise the priorities, not the adjectives.

20.3 Thirty practice questions, grouped by purpose

The following questions are deliberately framed at different levels. Some ask for a specific example; others ask for a view or a plan. Select the right approach rather than answering every question with the same framework.

Personal contribution and motivation

Tell us about your journey and why you are ready for a consultant post now.

What three qualities would you bring to this department?

Why do you want this job, in this organisation, at this stage of your career?

What makes you different from other appointable candidates?

What have you learnt from the most difficult feedback you have received?

What would colleagues say is challenging about working with you?

Leadership and relationships

Describe a change you led when you had no formal authority over everyone involved.

What does compassionate leadership look like in a busy department?

Tell us about a disagreement with a colleague and what you did.

How would you deal with repeated undermining behaviour in an MDT?

A colleague appears unable to work safely. What would you do?

How would you support a trainee whose performance has deteriorated?

Service management and improvement

What should our department prioritise over the next two years?

How would you decide which service improvement to undertake first?

Describe a project that improved patient care. What is the evidence?

What would you do if a proposed change was unpopular with nursing colleagues?

How would you improve access without compromising safety?

What would your first 100 days look like?

Governance, quality and professional standards

What does clinical governance mean in your practice?

Tell us about a safety concern you raised or acted upon.

What does PSIRF change about learning from patient safety incidents?

A patient alleges serious harm from a delay. How would you respond?

How do you demonstrate that your teaching is effective?

What responsibilities do you have when a colleague raises a concern about bullying?

NHS, equity and the future

What do the three shifts in the 10 Year Health Plan mean for your specialty?

How would you contribute to a financially sustainable service?

How might AI help your department, and what safeguards would you require?

What would you do to improve equity of access for patients?

How should consultants work with services outside the hospital?

What would success in this post look like after two years?

20.4 Challenge questions: evidence and reflection

1. Which achievement best demonstrates what you would add to this particular service, and why?
2. Tell us about a project where the result was less impressive than you hoped. What did you learn?
3. What part of a successful project was genuinely your contribution?
4. Give an example where feedback changed your view of your own performance.
5. What would your colleagues say you still need to develop?

20.5 Challenge questions: values and relationships

1. Which trust value do you find hardest to maintain under pressure?
2. Tell us about a time you failed to demonstrate one of our values.
3. Describe a disagreement in which the other person had a legitimate point.
4. When have you made a necessary decision that damaged a relationship, and how did you address that?
5. How would you respond if a popular colleague repeatedly dismissed junior staff?

20.6 Challenge questions: delivery and judgement

1. How would you decide which of three worthwhile service improvements to prioritise?
2. What would make you stop a project that you had strongly supported?
3. How would you distinguish a genuine cash saving from released capacity?
4. What would you do if your proposed change improved average performance but worsened access for one group?
5. What should be different by the end of your first year, and what will depend on others?

20.7 Challenge questions: safety, education and the future

1. Tell us about a clinical mistake and what changed in your practice afterwards.
2. How would you know whether a patient safety action had reduced risk?
3. How would you respond to a trainee who says your teaching is not meeting their needs?
4. What would you need to know before introducing an AI-supported tool into this service?
5. Which national policy matters most to this post, and what is the main implementation difficulty?

20.8 Worksheet: the role and your contribution

Use concise notes and real evidence. Protect patient and colleague confidentiality.

Preparation prompt	Your notes
The three most important responsibilities in this post	
What the service needs the new appointee to contribute	
Three relevant capabilities, each with evidence	
What I still need to clarify with the employer	
A realistic first-year contribution and its dependencies	

20.9 Worksheet: a thematic evidence bank

Use concise notes and real evidence. Protect patient and colleague confidentiality.

Element	Your notes
The question this example answers	
Situation, purpose and headline outcome	
Theme one: challenge, my actions, skills demonstrated	
Theme two: challenge, my actions, skills demonstrated	
Theme three, where genuinely useful	
Result, limitations, reflection and transfer to this role	

20.10 Worksheet: trust values

Use concise notes and real evidence. Protect patient and colleague confidentiality.

Exact trust value	Positive example	When I fell short / what changed
Value 1		
Value 2		
Value 3		
Value 4		
Additional value, where applicable		

20.11 Worksheet: an NHS topic in four points

Use concise notes and real evidence. Protect patient and colleague confidentiality.

Prompt	Your notes
Issue and current source / date	
Three or four key points	
What this means for this specialty and local service	
My contribution, with one practical example	
The principal trade-off, uncertainty or implementation risk	

20.12 Worksheet: presentation planning

Use concise notes and real evidence. Protect patient and colleague confidentiality.

Question	Your notes
What exactly does the title ask me to do?	
My central answer in one sentence	
Two or three supporting priorities and evidence	
The principal constraint and how I would address it	
What success would look like	
Likely challenges and the shorter backup version	

PUT IT INTO PRACTICE

Assemble your final pack

Complete the worksheets selectively and reduce them to the few pages that help you retrieve your best evidence and local understanding.

Self-check: Does every example remain truthful, relevant, anonymous and capable of withstanding follow-up?

21

The six course mock interviews



Use these exact question sets during the course. Make notes on the feedback you receive and the improvements you will practise afterwards.

Each set below contains the five questions supplied for the course. Treat follow-up questions and timing as directed by your trainer. The wording is retained, including the terminology used in the original question set.

Mock interview 1

1. Looking back at your training, what do you feel went well and what could be improved?

2. How would you enthuse a Foundation Year 2 doctor to choose <specialty> as a career?

3. Would you be happy being an average consultant?

4. Tell me about your management experience.

5. What would you do if a consultant colleague was underperforming?

COURSE FEEDBACK

What to keep, what to change and what to practise

Most convincing evidence or explanation: _____

_____

One answer to reorganise or make more specific: _____

_____

Priority for the next practice: _____

_____

Mock interview 2

1. How would your colleagues describe you?

2. As a consultant, how will you make sure that your team is up to scratch?

3. What makes you think that you are a safe doctor?

4. Tell me about your worst teaching experience as a teacher (not a delegate).

5. Give me an example of something that you have done which improved the running of your current department.

COURSE FEEDBACK

What to keep, what to change and what to practise

Most convincing evidence or explanation: _____

_____

One answer to reorganise or make more specific: _____

_____

Priority for the next practice: _____

_____

Mock interview 3

1. When is the last time that you argued with a colleague?

2. Would you like to become a clinical director?

3. Tell us about your research experience.

4. In what way will you be able to contribute towards the development of our service?

5. How do you handle stress?

COURSE FEEDBACK

What to keep, what to change and what to practise

Most convincing evidence or explanation: _____

_____

One answer to reorganise or make more specific: _____

_____

Priority for the next practice: _____

_____

Mock interview 4

1. What can you bring this Trust?

2. How would you measure quality of care in your specialty?

3. Describe a situation where you had to deal with a conflict within your team or a multi-disciplinary team.

4. What does the word “professionalism” mean to you?

5. How do you know that you are a good teacher?

COURSE FEEDBACK

What to keep, what to change and what to practise

Most convincing evidence or explanation: _____

_____

One answer to reorganise or make more specific: _____

_____

Priority for the next practice: _____

_____

Mock interview 5

1. What are you looking forward to the most in your new post as a consultant?

2. When is the last time that you have had to call for senior help?

3. What is your experience of clinical governance?

4. How can you improve quality of care without increasing cost?

5. Do you think that all specialist trainees should do research?

COURSE FEEDBACK

What to keep, what to change and what to practise

Most convincing evidence or explanation: _____

_____

One answer to reorganise or make more specific: _____

_____

Priority for the next practice: _____

_____

Mock interview 6

1. How do you know that you are fit to become a consultant?

2. What are your career plans over the next 10 years?

3. Tell us about your teaching experience.

4. How do you keep your skills up to date?

5. Your Registrar reports to you that his SHO has been late for 20 minutes each morning over the past 4 days. How do you handle the situation?

COURSE FEEDBACK

What to keep, what to change and what to practise

Most convincing evidence or explanation: _____

_____

One answer to reorganise or make more specific: _____

_____

Priority for the next practice: _____

_____

22

NHS issues and specialty reading guide



Choose your reading, understand the main messages and apply them to the service. This directory is a preparation aid, not a requirement to read every document.

22.1 Read selectively, not exhaustively

You are preparing for an interview, not conducting a literature review. Start with the purpose, executive summary and principal recommendations. Read the parts that relate to the advertised post more closely. For each important issue, prepare three or four key points, the implications for your specialty and one realistic contribution you could make.

Three or four points are headings for your understanding, not a substitute for it. Be able to explain each point, recognise an implementation difficulty and respond to a follow-up question. Never claim to have read an entire report when you have only read its summary.

Read more deeply when a report concerns a major safety issue in your specialty, a responsibility central to the post, or a problem specifically identified by the employer. Use local strategy, quality information, current board papers and relevant audit results alongside national documents. A national report cannot tell you what is happening in one department today.

A USEFUL STOPPING RULE

Four questions to answer before reading more

Why was the document produced? What three or four messages matter most? What do they mean for this particular service? What would I do, and how would I know it had helped?

Once you can answer those questions credibly, move on to practising the explanation. Return to the document when a detail matters or a follow-up question exposes a gap.

How to use the directory

The general table identifies themes worth considering across specialties. The specialty tables cover the 65 GMC specialty curricula, 30 recognised subspecialties and 13 GDC dental specialties. General practice is included for completeness of the specialty directory, although it does not usually follow an NHS consultant appointment route.

Select one or two starting documents from the one-to-four listed for your role. Codes are navigation labels: click one to reach a concise summary and the official publication link. Each summary explains the document's purpose, key findings or priorities, and main recommendations. A shared document is summarised once rather than repeated under several specialties.

For smaller specialties, relevant service standards and curricula can be more useful than forcing an unrelated national report into the answer. For paediatric subspecialties, the Progress+ page links to the named specialty syllabus: select the one matching your post. Add the employer's specific service specification and audit information. These starting points are not a complete clinical reading list. Chapter 23 provides a country-specific reading layer: it does not replace the specialty sources, but helps you check their geographical scope and local applicability.

Scope and dates

An England policy is not automatically a UK-wide policy. Check the national arrangements for Scotland, Wales, Northern Ireland or the Republic of Ireland and use the corresponding local strategy. A historic inquiry explains failures at a particular time; it does not describe the current performance of the organisation. Publication year, data year, recommendation and implementation are different things.

Some GIRFT pages provide a public executive summary while the full report requires professional platform access. Use the public summary first. Links lead to the publisher rather than an unofficial copy. This selection was checked in November 2026; read the publisher's update information before relying on a time-sensitive detail.

22.2 General NHS issues: what to consider

Issue	What to be ready to explain	Start with
Strategic direction and neighbourhood care	Explain the three shifts, local relevance and implementation constraints.	N01 10 Year Health Plan N02 Medium Term Planning Framework
Waiting lists, diagnostics and patient flow	Connect access, clinical prioritisation, capacity, outcomes and experience.	N02 Medium Term Planning Framework S25 Emergency medicine GIRFT
Finance, productivity and value	Distinguish waste reduction from unsafe cuts; examine whole-pathway effects.	N02 Medium Term Planning Framework N05 GMC leadership guidance
Workforce, delegation and changing roles	Discuss competence, supervision, retention and accountable service design.	N05 GMC leadership guidance N24 Leng review
Patient safety and learning from incidents	Explain immediate action, involvement, proportionate learning and tested improvement.	N03 PSIRF N06 Patient safety culture guide
Listening, escalation and family concerns	Describe how a concern changes assessment and how escalation works.	N18 Martha's Rule standards N12 Ockenden: Shrewsbury
Psychological safety and speaking up	Invite challenge, respond fairly, close the loop and prevent retaliation.	N06 Patient safety culture guide N10 Freedom to Speak Up
Positive culture and consultant leadership	Connect standards, role-modelling, work design and fair accountability.	N05 GMC leadership guidance N06 Patient safety culture guide N11 Berwick: A Promise to Learn
Workforce equality, diversity, equity and inclusion	Identify barriers, distribute opportunity fairly and evaluate staff experience.	N07 NHS EDI improvement plan N19 WRES N20 WDES
Health inequalities and prevention	Understand who is underserved, involve them and test a targeted response.	N08 Core20PLUS5 S38 CMO physical activity guidance
Patient involvement and appropriate care	Discuss options, uncertainty and what matters to the individual.	N21 Shared decision making N15 Cumberlege: First Do No Harm

Issue	What to be ready to explain	Start with
Quality, governance and organisational oversight	Bring data, patient experience and staff concerns together to identify risk.	N09 Francis: Mid Staffordshire N16 Paterson Inquiry N17 Infected Blood Inquiry
Digital transformation and cybersecurity	Consider safety, accessibility, information governance and continuity during disruption.	N01 10 Year Health Plan N22 Cybersecurity strategy
Research, innovation and genomics	Separate benefit, evidence, consent, oversight and implementation.	S35 Genome UK S36 HRA Good Clinical Practice
Antimicrobial resistance and infection prevention	Connect prevention, diagnostics, stewardship and cross-setting work.	S37 Antimicrobial resistance plan
Environmental sustainability	Discuss an appropriate change, trade-offs and measurable resource implications.	N23 Green Plan guidance
Cancer pathways and long-term support	Connect prevention, diagnosis, treatment capacity and personalised care.	S56 National Cancer Plan
Major inquiries and safety reviews	Know the context, three or four lessons and what you would do differently.	N09 Francis: Mid Staffordshire N12 Ockenden: Shrewsbury N14 Kirkup: East Kent N15 Cumberlege: First Do No Harm
Candour, patient voice and public trust	Discuss openness, consent, learning and resistance to organisational defensiveness.	N04 Good medical practice N16 Paterson Inquiry N17 Infected Blood Inquiry
Employer-specific priorities	Use the local strategy, quality report, board papers and relevant service audit.	N02 Medium Term Planning Framework N05 GMC leadership guidance

22.3 Medical specialties

The focus column indicates how to use the reading in a consultant interview. Read the relevant part, not every chapter. The same report may support several different specialties.

Specialty	Reports or documents	Interview focus
Acute internal medicine	S01 Acute medicine GIRFT S25 Emergency medicine GIRFT N02 Medium Term Planning Framework F02 Sepsis MSF	Acute assessment, same-day care, flow and consultant decision-making.
Allergy	S50 Adult allergy specification N08 Core20PLUS5	Specialist access, safe pathways and inequality in referral or treatment.
Anaesthetics	S26 GPAS: The Good Department S27 GPICS intensive care standards N03 PSIRF	Perioperative organisation, workforce, supervision and safety.

Specialty	Reports or documents	Interview focus
Audio vestibular medicine	S31 Hearing loss: NG98 S08 Neurology GIRFT N21 Shared decision making	Diagnostic access, communication needs and coordinated rehabilitation.
Aviation and space medicine	S33 CAA aeromedical guidance N04 Good medical practice	Role-specific fitness assessment, public safety and independent judgement.
Cardio-thoracic surgery	S13 Cardiothoracic surgery GIRFT S51 National Cardiac Audit Programme N03 PSIRF F01 Cardiovascular disease MSF	Networks, critical care capacity, timely surgery and outcomes.
Cardiology	S51 National Cardiac Audit Programme N08 Core20PLUS5 N02 Medium Term Planning Framework F01 Cardiovascular disease MSF	Timely treatment, prevention, rehabilitation and equitable access.
Chemical pathology	S09 Pathology GIRFT S40 Medicines optimisation: NG5 S53 National Diabetes Audit	Diagnostic stewardship, metabolic pathways and reliable interpretation.
Child and adolescent psychiatry	S07 Children's mental health GIRFT S29 NCISH annual report S46 Learning disability: NG11	Crisis pathways, families, transition and coordinated specialist care.
Clinical genetics	S35 Genome UK N21 Shared decision making N08 Core20PLUS5	Genomic pathways, consent, counselling and equitable access.
Clinical neurophysiology	S08 Neurology GIRFT S09 Pathology GIRFT N02 Medium Term Planning Framework	Timely diagnostic expertise, clinical interfaces and workforce capacity.
Clinical oncology	S42 Oncology workforce census S56 National Cancer Plan D03 IR(ME)R guidance	Treatment capacity, radiotherapy governance and personalised cancer care.
Clinical pharmacology and therapeutics	S40 Medicines optimisation: NG5 S36 HRA Good Clinical Practice N15 Cumberlege: First Do No Harm	Safe medicines systems, research and response to treatment-related harm.
Clinical radiology	S41 Radiology workforce census D03 IR(ME)R guidance S56 National Cancer Plan	Imaging demand, reporting capacity, safety and cancer pathways.
Community sexual and reproductive health	S45 Sexual and reproductive health standards N08 Core20PLUS5 N21 Shared decision making	Open access, individual choice, confidentiality and prevention.
Dermatology	S02 Dermatology GIRFT S56 National Cancer Plan N08 Core20PLUS5	Triage, digital pathways, skin cancer and fair access.

Specialty	Reports or documents	Interview focus
Diagnostic neuropathology	S09 Pathology GIRFT S08 Neurology GIRFT S35 Genome UK	Specialist diagnosis, molecular testing and timely clinical communication.
Emergency medicine	S25 Emergency medicine GIRFT N18 Martha's Rule standards S59 Violence and aggression: NG10 F02 Sepsis MSF	Crowding, escalation, patient concerns and safe crisis responses.
Endocrinology and diabetes mellitus	S03 Endocrinology GIRFT S53 National Diabetes Audit N08 Core20PLUS5 F01 Cardiovascular disease MSF	Specialist endocrine networks, reliable diabetes care and inequalities.
Forensic histopathology	S39 Forensic pathology protocol S09 Pathology GIRFT N04 Good medical practice	Independence, quality assurance and multi-agency responsibilities.
Forensic psychiatry	S29 NCISH annual report S59 Violence and aggression: NG10 S58 Drug dependence: Orange Book	Safe care, restrictive practice, recovery and justice-system interfaces.
Gastro-enterology	S04 Gastroenterology GIRFT S56 National Cancer Plan N08 Core20PLUS5	Diagnostic capacity, emergency access and proactive chronic disease care.
General (internal) medicine	S01 Acute medicine GIRFT S05 Geriatric medicine GIRFT S40 Medicines optimisation: NG5 F04 Frailty pathways guide	Complexity, frailty, medicines and cross-specialty coordination.
General practice	N01 10 Year Health Plan N08 Core20PLUS5 S53 National Diabetes Audit	Neighbourhood care, prevention and reliable long-term condition pathways.
General psychiatry	S29 NCISH annual report S24 Mental health rehabilitation GIRFT S59 Violence and aggression: NG10 F03 Mental health personalised care	Continuity, crisis care, rehabilitation and safer environments.
General surgery	S16 General surgery GIRFT S56 National Cancer Plan N16 Paterson Inquiry	Emergency flow, elective care, consent and scrutiny of practice.
Genito-urinary medicine	S45 Sexual and reproductive health standards S37 Antimicrobial resistance plan N08 Core20PLUS5	Accessible sexual health, prevention, stewardship and confidentiality.
Geriatric medicine	S05 Geriatric medicine GIRFT S40 Medicines optimisation: NG5 S43 NACEL end-of-life care audit F04 Frailty pathways guide	Function, frailty, appropriate medicines and individualised care.

Specialty	Reports or documents	Interview focus
Haematology	S54 SHOT transfusion safety report N17 Infected Blood Inquiry S56 National Cancer Plan	Transfusion safety, treatment pathways, consent and learning from harm.
Histopathology	S09 Pathology GIRFT S56 National Cancer Plan S35 Genome UK	Diagnostic networks, cancer pathways, genomics and quality assurance.
Immunology	S49 Adult immunology specification S50 Adult allergy specification S37 Antimicrobial resistance plan	Specialist networks, home therapy, infection prevention and access.
Infectious diseases	S37 Antimicrobial resistance plan N08 Core20PLUS5 N03 PSIRF F02 Sepsis MSF	Prevention, diagnostics, stewardship and safe cross-setting care.
Intensive care medicine	S27 GPICS intensive care standards S26 GPAS: The Good Department N03 PSIRF F02 Sepsis MSF	Multidisciplinary provision, escalation, resources and safety assurance.
Medical microbiology	S37 Antimicrobial resistance plan S09 Pathology GIRFT N03 PSIRF F02 Sepsis MSF	Stewardship, laboratory-clinical integration and learning from infection events.
Medical oncology	S56 National Cancer Plan S36 HRA Good Clinical Practice N21 Shared decision making	Cancer pathways, research, treatment decisions and supportive care.
Medical ophthalmology	S17 Ophthalmology GIRFT S53 National Diabetes Audit N08 Core20PLUS5	Monitoring capacity, medical eye disease and equitable access.
Medical psychotherapy	S47 Personality disorder: CG78 S29 NCISH annual report N05 GMC leadership guidance	Therapeutic service design, continuity, supervision and crisis interfaces.
Medical virology	S09 Pathology GIRFT S37 Antimicrobial resistance plan N22 Cybersecurity strategy	Diagnostic networks, infection prevention and resilient services.
Neurology	S08 Neurology GIRFT S52 National Stroke Guideline S30 Trauma rehabilitation: NG211	Access, multidisciplinary pathways and rehabilitation interfaces.
Neurosurgery	S14 Cranial neurosurgery GIRFT S30 Trauma rehabilitation: NG211 N03 PSIRF	Specialist networks, urgent access and outcomes beyond surgery.
Nuclear medicine	S34 ARSAC guidance D03 IR(ME)R guidance S56 National Cancer Plan	Radiopharmaceutical governance, capacity and integrated diagnostic pathways.

Specialty	Reports or documents	Interview focus
Obstetrics and gynaecology	N12 Ockenden: Shrewsbury N13 Ockenden: Nottingham N14 Kirkup: East Kent N15 Cumberlege: First Do No Harm	Maternity safety, listening, escalation and treatment-related harm.
Occupational medicine	S32 SEQOHS standards N20 WDES N07 NHS EDI improvement plan	Quality occupational health, adjustments and staff experience.
Old age psychiatry	S29 NCISH annual report S05 Geriatric medicine GIRFT S43 NACEL end-of-life care audit F03 Mental health personalised care	Older people's safety, physical health, continuity and end-of-life care.
Ophthalmology	S17 Ophthalmology GIRFT N08 Core20PLUS5 N02 Medium Term Planning Framework	Capacity, outcome monitoring and reliable access to review.
Oral and maxillo-facial surgery	S18 Maxillofacial surgery GIRFT S06 Hospital dentistry GIRFT S56 National Cancer Plan	Specialist networks, dental interfaces and head and neck pathways.
Otolaryngology	S15 ENT GIRFT S31 Hearing loss: NG98 S56 National Cancer Plan	ENT access, day-case pathways and communication needs.
Paediatric and perinatal pathology	S09 Pathology GIRFT S55 National Neonatal Audit Programme N12 Ockenden: Shrewsbury	Diagnostic quality, communication and perinatal learning.
Paediatric cardiology	S51 National Cardiac Audit Programme S28 Facing the Future standards S48 RCPCH Progress+ syllabi	Congenital pathways, family involvement and transition.
Paediatric surgery	S20 Paediatric surgery GIRFT S28 Facing the Future standards S48 RCPCH Progress+ syllabi	Regional networks, expertise, safe access and family experience.
Paediatrics	S28 Facing the Future standards S48 RCPCH Progress+ syllabi S55 National Neonatal Audit Programme	Acute services, safeguarding, family partnership and training standards.
Palliative medicine	S43 NACEL end-of-life care audit S44 Children's end-of-life care: NG61 N21 Shared decision making	Individualised care, communication and coordination across settings.
Pharmaceutical medicine	S36 HRA Good Clinical Practice S40 Medicines optimisation: NG5 N15 Cumberlege: First Do No Harm	Research integrity, medicines safety and patient voice.
Plastic surgery	S21 Plastic surgery GIRFT S30 Trauma rehabilitation: NG211 N16 Paterson Inquiry	Trauma and reconstruction pathways, outcomes and governance.
Psychiatry of learning disability	S46 Learning disability: NG11 S59 Violence and aggression: NG10 N08 Core20PLUS5	Accessible care, positive support and avoidance of unnecessary restriction.

Specialty	Reports or documents	Interview focus
Public health medicine	N01 10 Year Health Plan N08 Core20PLUS5 S37 Antimicrobial resistance plan S38 CMO physical activity guidance	Prevention, inequality, population evidence and cross-sector action.
Rehabilitation medicine	S30 Trauma rehabilitation: NG211 S38 CMO physical activity guidance N20 WDES	Person-centred goals, participation and coordinated community provision.
Renal medicine	S10 Renal medicine GIRFT N08 Core20PLUS5 N21 Shared decision making F01 Cardiovascular disease MSF	Treatment choice, equitable transplant access and home therapy support.
Respiratory medicine	S11 Respiratory medicine GIRFT S37 Antimicrobial resistance plan N08 Core20PLUS5	Acute support, chronic pathways, prevention and inequality.
Rheumatology	S12 Rheumatology GIRFT S40 Medicines optimisation: NG5 N21 Shared decision making	Access, medicines, shared decisions and appropriate follow-up.
Sport and exercise medicine	S38 CMO physical activity guidance S30 Trauma rehabilitation: NG211 N08 Core20PLUS5	Physical activity, rehabilitation and accessible participation.
Trauma and orthopaedic surgery	S19 Orthopaedic surgery GIRFT S30 Trauma rehabilitation: NG211 N16 Paterson Inquiry	Elective reliability, recovery, outcomes and appropriate intervention.
Tropical medicine	S37 Antimicrobial resistance plan N08 Core20PLUS5 N04 Good medical practice	Infection pathways, migration-related barriers and professional judgement.
Urology	S22 Urology GIRFT S56 National Cancer Plan N21 Shared decision making	Definitive pathways, specialist nursing and treatment choices.
Vascular surgery	S23 Vascular surgery GIRFT S30 Trauma rehabilitation: NG211 N08 Core20PLUS5	Timely network care, prevention and rehabilitation.

22.4 Recognised subspecialties

Specialty	Reports or documents	Interview focus
Addiction psychiatry	S58 Drug dependence: Orange Book S29 NCISH annual report S59 Violence and aggression: NG10	Recovery, physical health, continuity and crisis responses.
Child mental health	S07 Children's mental health GIRFT S28 Facing the Future standards S48 RCPCH Progress+ syllabi	Paediatric-mental health interfaces and developmentally appropriate care.

Specialty	Reports or documents	Interview focus
Community child health	S48 RCPCH Progress+ syllabi S46 Learning disability: NG11 N08 Core20PLUS5	Participation, development, inclusion and multi-agency coordination.
Congenital cardiac surgery	S51 National Cardiac Audit Programme S13 Cardiothoracic surgery GIRFT S28 Facing the Future standards	Congenital networks, family communication and lifelong pathways.
Cytopathology	S09 Pathology GIRFT S56 National Cancer Plan N03 PSIRF	Diagnostic accuracy, specimen pathways and reliable escalation.
Gynaecological oncology	S56 National Cancer Plan N16 Paterson Inquiry N21 Shared decision making	Cancer pathways, multidisciplinary decisions and informed consent.
Hepatology	S04 Gastroenterology GIRFT S58 Drug dependence: Orange Book N08 Core20PLUS5	Integrated liver services, prevention and access to specialist support.
Interventional radiology	S41 Radiology workforce census D03 IR(ME)R guidance N03 PSIRF	On-call expertise, procedural safety and cross-specialty access.
Liaison psychiatry	S29 NCISH annual report S59 Violence and aggression: NG10 S25 Emergency medicine GIRFT	Emergency and inpatient interfaces, continuity and crisis care.
Maternal and fetal medicine	N12 Ockenden: Shrewsbury N13 Ockenden: Nottingham N14 Kirkup: East Kent N21 Shared decision making	Specialist oversight, multidisciplinary decisions and listening to families.
Neonatal medicine	S55 National Neonatal Audit Programme N13 Ockenden: Nottingham N14 Kirkup: East Kent S28 Facing the Future standards	Perinatal networks, parental partnership, staffing and outcomes.
Paediatric allergy, immunology and infectious diseases	S48 RCPCH Progress+ syllabi S37 Antimicrobial resistance plan N08 Core20PLUS5	Specialist networks, prevention, access and transition; use the relevant paediatric syllabus.
Paediatric clinical pharmacology and therapeutics	S48 RCPCH Progress+ syllabi S40 Medicines optimisation: NG5 S36 HRA Good Clinical Practice	Children's medicines, research governance and safety systems.
Paediatric diabetes and endocrinology	S48 RCPCH Progress+ syllabi S28 Facing the Future standards N08 Core20PLUS5	Family-supported chronic care, access and transition to adult services.
Paediatric emergency medicine	S28 Facing the Future standards S25 Emergency medicine GIRFT S48 RCPCH Progress+ syllabi	Child-specific expertise, urgent pathways and safe escalation.

Specialty	Reports or documents	Interview focus
Paediatric gastroenterology, hepatology and nutrition	S48 RCPCH Progress+ syllabi S28 Facing the Future standards N21 Shared decision making	Specialist networks, nutritional needs and family-centred decisions.
Paediatric inherited metabolic medicine	S48 RCPCH Progress+ syllabi S35 Genome UK S40 Medicines optimisation: NG5	Genomic diagnosis, emergency plans and coordinated long-term care.
Paediatric intensive care medicine	S48 RCPCH Progress+ syllabi S28 Facing the Future standards N03 PSIRF	Child-specific critical care capability, networks and family support.
Paediatric nephrology	S48 RCPCH Progress+ syllabi S28 Facing the Future standards N21 Shared decision making	Long-term treatment, family decisions and transition.
Paediatric neurodisability	S48 RCPCH Progress+ syllabi S46 Learning disability: NG11 N08 Core20PLUS5	Participation, accessibility and coordinated multi-agency support.
Paediatric neurology	S48 RCPCH Progress+ syllabi S28 Facing the Future standards N21 Shared decision making	Specialist access, family communication and transition.
Paediatric oncology	S48 RCPCH Progress+ syllabi S56 National Cancer Plan S44 Children's end-of-life care: NG61	Age-appropriate cancer care, family support and palliative interfaces.
Paediatric palliative medicine	S44 Children's end-of-life care: NG61 S48 RCPCH Progress+ syllabi N21 Shared decision making	Advance planning, family choices and coordinated care across settings.
Paediatric respiratory medicine	S48 RCPCH Progress+ syllabi S28 Facing the Future standards S37 Antimicrobial resistance plan	Specialist pathways, prevention and coordinated chronic care.
Paediatric rheumatology	S48 RCPCH Progress+ syllabi S40 Medicines optimisation: NG5 N21 Shared decision making	Safe medicines, participation and shared decisions with families.
Pre-hospital emergency medicine	S25 Emergency medicine GIRFT S26 GPAS: The Good Department N03 PSIRF	System coordination, timely expertise and transfer of responsibility.
Rehabilitation psychiatry	S24 Mental health rehabilitation GIRFT S29 NCISH annual report N08 Core20PLUS5	Recovery, community provision, housing and equitable access.
Reproductive medicine	S57 HFEA Code of Practice S45 Sexual and reproductive health standards N21 Shared decision making	Licensed services, consent, counselling and fair treatment choices.

Specialty	Reports or documents	Interview focus
Stroke medicine	S52 National Stroke Guideline S30 Trauma rehabilitation: NG211 N08 Core20PLUS5	Hyperacute access, rehabilitation, prevention and inequalities.
Urogynaecology	N15 Cumberlege: First Do No Harm S22 Urology GIRFT N21 Shared decision making	Treatment-related harm, meaningful consent and pelvic floor pathways.

22.5 Dental specialties

Specialty	Reports or documents	Interview focus
Dental and Maxillofacial Radiology	D03 IR(ME)R guidance S06 Hospital dentistry GIRFT D01 Standards for the dental team	Imaging justification, reporting and dental pathway integration.
Dental Public Health	D02 Delivering Better Oral Health S06 Hospital dentistry GIRFT N08 Core20PLUS5	Population oral health, prevention and equitable service access.
Endodontics	S06 Hospital dentistry GIRFT D01 Standards for the dental team D02 Delivering Better Oral Health	Referral complexity, appropriate intervention and prevention.
Oral and Maxillofacial Pathology	S09 Pathology GIRFT S06 Hospital dentistry GIRFT D01 Standards for the dental team	Diagnostic quality, laboratory networks and clinical communication.
Oral Medicine	S06 Hospital dentistry GIRFT D01 Standards for the dental team N21 Shared decision making	Complex diagnosis, multidisciplinary care and shared decisions.
Oral Microbiology	S37 Antimicrobial resistance plan S09 Pathology GIRFT S06 Hospital dentistry GIRFT	Stewardship, laboratory-clinical integration and oral infection pathways.
Oral Surgery	S06 Hospital dentistry GIRFT S18 Maxillofacial surgery GIRFT D01 Standards for the dental team	Complexity-based referral, consent and access to safe care.
Orthodontics	S06 Hospital dentistry GIRFT D01 Standards for the dental team N21 Shared decision making	Appropriate referral, informed choices and coordinated treatment.
Paediatric Dentistry	S06 Hospital dentistry GIRFT D02 Delivering Better Oral Health S28 Facing the Future standards	Prevention, children's access, family involvement and hospital capacity.
Periodontics	S06 Hospital dentistry GIRFT D02 Delivering Better Oral Health D01 Standards for the dental team	Prevention, long-term care and equitable access to specialist treatment.
Prosthodontics	S06 Hospital dentistry GIRFT D01 Standards for the dental team N21 Shared decision making	Rehabilitation, patient expectations and appropriate use of specialist resources.

Specialty	Reports or documents	Interview focus
Restorative Dentistry	S06 Hospital dentistry GIRFT D02 Delivering Better Oral Health N21 Shared decision making	Multidisciplinary planning, rehabilitation and prevention.
Special Care Dentistry	S06 Hospital dentistry GIRFT D01 Standards for the dental team N08 Core20PLUS5	Accessible care, adjustments and coordinated support for complex needs.

22.6 Report summaries: key findings and recommendations

These summaries explain what each document says. Read the relevant entries to understand the main issues, then use the official links for recommendations or sections that need closer attention. Publication dates and proposals should not be confused with evidence of completed implementation.

N01 Fit for the Future: 10 Year Health Plan for England (2025)

England | National strategy

Published in 2025, this plan sets out how the NHS in England should change over ten years. Its three central shifts are from hospital to community, analogue to digital, and sickness to prevention. The intention is to provide more coordinated care earlier, rather than relying on hospitals to respond once people become seriously unwell.

Neighbourhood health services would bring professionals together around patients, especially those with complex or long-term conditions. More care, diagnostics and urgent support would be available close to home. Hospitals would concentrate on specialist treatment, while shared care plans and stronger links with primary care reduce fragmentation.

The digital proposals include a single patient record, a substantially expanded NHS App and greater use of artificial intelligence. Prevention priorities include smoking, obesity, vaccination and earlier identification of disease. These changes are supported by proposals for workforce development, greater local autonomy, clearer quality information and funding that rewards better outcomes. The document describes a programme of reform, not changes already implemented everywhere. Read document

N02 Medium Term Planning Framework 2026/27 to 2028/29

England | Operational planning

This framework translates England's longer-term health strategy into delivery priorities for 2026/27 to 2028/29. It requires organisations to connect service improvement with workforce, financial and capacity planning, rather than pursue access targets separately from the resources needed to achieve them.

The headline commitments include restoring 92% performance against the 18-week elective standard by the end of 2028/29, improving cancer and diagnostic waiting times, reducing very long emergency department waits and improving ambulance response times. Primary care access, community waiting times, mental health provision and reducing inappropriate inpatient care for people with learning disabilities and autistic people are also priorities.

Delivery depends on changing how care is organised: expanding neighbourhood services, making better use of digital systems, strengthening prevention and improving productivity. The framework combines financial discipline with greater local responsibility and expects credible multi-year plans. It therefore links recovery of today's services with redesign for future demand, rather than treating extra activity alone as the solution. Read document

N03 Patient Safety Incident Response Framework (PSIRF)

England | Patient safety framework

PSIRF replaces the Serious Incident Framework in England and changes the purpose of incident response from applying a severity threshold to identifying useful learning and achieving safer care. It removes the separate 'Serious Incident' classification and promotes proportionate responses based on the circumstances, learning potential and existing improvement work.

N03 Patient Safety Incident Response Framework (PSIRF)
England | Patient safety framework

Its four principles are compassionate involvement of patients, families and staff; system-based learning; proportionate responses; and supportive oversight. Investigations should examine how tasks, equipment, staffing, communication and working conditions interacted, rather than assume that one person's error explains the event. Different methods, including thematic reviews, may be more useful than repeatedly investigating similar incidents.

Providers must publish a response policy and plan, involve those affected and translate learning into improvement whose effectiveness is monitored. PSIRF learning responses are not designed to allocate blame, establish culpability or determine cause of death. Employment, professional-regulatory, criminal and coronial processes retain separate purposes and must not be conflated with the learning response. Read document

N04 Good medical practice
UK | Professional standards

Good medical practice sets out the GMC's core professional expectations. The current framework places safe, competent care alongside partnership with patients, effective working relationships and maintenance of trust. It is relevant to everyday clinical conduct, not only to exceptional ethical dilemmas.

Doctors must keep their knowledge and skills up to date, work within their competence and seek appropriate support. Patients should receive understandable information and be supported to make decisions that reflect their circumstances and preferences. Accurate records, continuity of care and reliable communication are part of safe practice.

The standards also require respectful treatment of colleagues and a compassionate, supportive and fair working environment. Doctors should act when patient safety or dignity is threatened, be honest about mistakes and cooperate with learning and improvement. Leadership responsibilities therefore include how a consultant responds to challenge, discrimination and concerns about care, as well as the quality of their own clinical decisions. Read document

N05 Leadership and management for all doctors
UK | Professional leadership

This GMC guidance makes leadership and management responsibilities relevant to all doctors, not just those holding a clinical director or managerial title. It covers working with colleagues, employment matters, teaching, resource use and the development of services.

Effective teams need clear responsibilities, respectful communication and recognition of each professional's contribution. Delegation and supervision must reflect competence and the task involved. Doctors with responsibility for others should support development, provide constructive feedback and address performance or behaviour concerns fairly, while protecting patients.

Resources should be used responsibly and decisions should consider the needs of patients beyond an individual consultation. Service improvement requires cooperation, reliable information and accountability for decisions. Where resource constraints or organisational arrangements threaten safety, the response should include appropriate escalation rather than silent acceptance. The guidance links clinical leadership with both staff support and a willingness to take necessary action. Read document

N06 Improving patient safety culture: a practical guide
England | Culture and improvement

This practical guide explains how everyday behaviour and working arrangements create or undermine a patient safety culture. It brings together psychological safety, fairness, inclusion, civility, teamwork and communication rather than treating culture as a statement of organisational values.

Psychological safety means people can ask questions, admit uncertainty, report mistakes and challenge decisions without humiliation or unfair consequences. It does not mean avoiding disagreement. Leaders need to invite contributions, respond constructively and recognise that hierarchy or exclusion may prevent some staff from being heard.

The guide also encourages a fair, learning-focused response when things go wrong, attention to staff wellbeing and reliable communication across professional boundaries. Practical improvement starts with understanding how the team currently experiences its work, selecting specific changes and checking their effect. A reporting process alone is insufficient: staff need evidence that speaking up leads to a response and that safety concerns result in action. Read document

N07 NHS equality, diversity and inclusion improvement plan

England | Workforce inclusion

The NHS equality, diversity and inclusion improvement plan sets out six high-impact actions intended to improve staff experience and belonging. It treats inclusion as a leadership and organisational responsibility, rather than something achieved solely through mandatory training.

The actions address accountable leadership, fair recruitment and progression, pay gaps, staff health inequalities, support for internationally recruited staff, and the conditions that permit bullying, discrimination, harassment or violence. Organisations are expected to examine differences in opportunity and treatment, including within disciplinary and employee-relations processes.

Implementation requires workforce data, staff feedback and clear responsibility for improvement. Support for affected staff, safe routes to raise concerns and preventative action are central. The plan recognises that disadvantages can overlap and that a single organisation-wide average may conceal unequal experiences. Its emphasis is on changing employment practices and working conditions, with progress assessed through outcomes and staff experience rather than the existence of an action plan. Read document

N08 Core20PLUS5: reducing healthcare inequalities

England | Population health approach

Core20PLUS5 is NHS England's approach to focusing improvement on groups experiencing the greatest healthcare inequalities. 'Core20' refers to the most deprived 20% of the population. 'PLUS' covers additional groups identified locally as experiencing poorer access, experience or outcomes, including people whose needs may be hidden within population averages.

For adults, the five clinical priorities are maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and identification and management of hypertension, alongside lipid optimisation. Examples of the intended action include improving physical health checks for people with severe mental illness, respiratory vaccination and earlier detection of cardiovascular risk.

There is a separate children and young people's framework with age-appropriate priorities. The approach combines national direction with local evidence: services need to identify which groups are missing out, understand the barriers and direct improvement accordingly. It is not simply a deprivation label or a request to provide identical services to everyone; it is a method for narrowing avoidable differences in care. Read document

N09 Francis: Mid Staffordshire Public Inquiry (2013)

England | Historical inquiry

The Francis inquiry examined how serious failures at Mid Staffordshire were allowed to persist despite warning signs. It found an organisational culture in which financial and performance priorities could displace attention to basic care, dignity and the experiences of patients and families.

The failures extended beyond individual clinical decisions. Staff concerns were not reliably heard, poor standards became tolerated, and boards, regulators and other oversight bodies failed to build an accurate picture of care. Meeting selected targets did not provide sufficient assurance that patients were safe or treated compassionately.

The recommendations centred on putting patients first, clearer standards, openness, transparency and stronger accountability. Leadership needed to listen to complaints and staff concerns, use meaningful information about care and respond when standards deteriorated. The report's enduring message is that governance must test the reality of patients' experience, rather than rely on reassuring performance reports or an organisation's reputation. Read document

N10 Francis: Freedom to Speak Up review (2015)

England | Speaking up review

The Freedom to Speak Up review examined the treatment of NHS workers who raised concerns. It found that speaking up could expose staff to bullying, isolation and damage to their careers, while the original concerns remained unresolved. This discouraged others from raising problems and weakened organisational learning.

The review recommended a local Freedom to Speak Up Guardian, independent national leadership, clearer procedures for handling concerns and training for managers and staff. It also proposed support for people disadvantaged after speaking up and greater accountability for those who mistreated them.

N10 Francis: Freedom to Speak Up review (2015)

England | Speaking up review

The central requirement was a change in culture: concerns should be treated as a contribution to improvement, investigated fairly and followed by meaningful feedback. A named guardian or reporting policy is not enough if staff still fear retaliation. Leaders must make it safe to raise concerns, act on what is reported and protect the people involved while preserving fair treatment for everyone. Read document

N11 Berwick: A Promise to Learn - A Commitment to Act (2013)

England | Patient safety review

Commissioned following the Francis inquiry, Berwick's review argues that patient safety depends on a healthcare system that continually learns and improves. Its central priority is to place the quality and safety of patients' care above other organisational objectives.

The report recommends involving patients and carers as partners, developing improvement skills throughout the workforce and making information about safety transparent. Numerical targets should be used cautiously: they can help improvement but should never replace the underlying purpose of providing better care.

It rejects blame as the routine response to error and emphasises understanding and improving the systems in which staff work. This is not an argument for abandoning accountability; it is a distinction between learning from ordinary human fallibility and responding appropriately to unacceptable conduct. Sustained leadership, staff development and an environment in which concerns can be discussed openly are presented as the foundations of safer care. Read document

N12 Ockenden: Shrewsbury and Telford final report (2022)

England | Maternity safety review

The 2022 Ockenden review investigated serious failings in maternity services at Shrewsbury and Telford Hospital NHS Trust and identified essential improvements for services across England. It found repeated failures to assess risk, recognise deterioration and obtain timely senior involvement. Women's concerns were dismissed, while poor relationships between professions hindered escalation.

A particular concern was the emphasis on low caesarean section rates. The review found that this had contributed to harm and supported ending overall caesarean rates as a performance measure. Decisions should instead reflect individual risk, informed choice and appropriate clinical assessment.

Staffing shortages, training gaps and inadequate consultant support undermined care. Recommendations included sustainable workforce investment, protected multidisciplinary training, emergency drills and clearer requirements for senior attendance and escalation.

Poor investigations and weak oversight allowed failures to recur. The review called for family involvement, stronger accountability and evidence that recommendations change practice, rather than simply closing an action plan. Listening, safe decisions, effective teamwork and demonstrable learning are the central messages. Read document

N13 Ockenden: Nottingham University Hospitals final report (2026)

England | Maternity and neonatal safety review

Published in 2026, this separate Ockenden review examined maternity and neonatal care at Nottingham University Hospitals, predominantly between 2012 and 2025. It describes recurring failures in communication, assessment, observation and escalation, alongside staffing pressures and a culture in which concerns were not consistently heard or acted upon.

Families reported loss of choice and involvement, insensitive responses and further distress when investigations or explanations were inadequate. Staff accounts described bullying, intimidating groups and leaders who were difficult to approach or unresponsive. The report stresses that good individual practice cannot compensate for persistent weaknesses in leadership, staffing and oversight.

Its immediate and essential actions cover listening to women and families; workforce planning and safe staffing; multiprofessional learning; risk assessment throughout pregnancy; investigations involving families; board accountability; teamwork and psychological safety; and care after a mother's death. It also emphasises learning from the quality of care processes, including successful prevention of harm, rather than judging care solely by whether the eventual outcome was good or bad. Read document

N14 Kirkup: Reading the Signals - East Kent (2022)

England | Maternity and neonatal investigation

Bill Kirkup's investigation into maternity and neonatal services in East Kent found serious failures in care alongside damaged relationships, poor professional behaviour and defensive organisational responses. Warning signs did not reliably lead to recognition of the problem or effective intervention.

The report identifies four areas for action: better identification of poorly performing units, compassionate and kind care, teamwork with a shared purpose, and honest responses to challenge. These themes connect clinical performance with the way staff treat families, collaborate across professional boundaries and respond when their practice is questioned.

The recommendations seek more meaningful use of information about outcomes, stronger attention to professional behaviour and a culture that prioritises patients over institutional reputation. The report is particularly concerned with recognising signals early and responding to them, rather than waiting for repeated serious harm. It therefore treats kindness, teamwork and openness as elements of safe care, not optional additions to technical competence. Read document

N15 Cumberlege: First Do No Harm (2020)

UK | Medicines and devices safety review

The Cumberlege review examined how the health system responded to concerns about pelvic mesh, sodium valproate and hormone pregnancy tests such as Primodos. It found that patients' reports of harm were too often dismissed and that fragmented systems failed to connect emerging concerns with effective action.

The report's themes include listening to patients, meaningful consent, monitoring longer-term outcomes and improving the response to treatment-related harm. It recommended an independent Patient Safety Commissioner, better information on implanted devices, specialist support for affected patients and arrangements for redress. These were recommendations of the review; implementation decisions are separate.

A major practical issue is traceability: information about a device, the procedure and the patient's subsequent outcomes needs to be linked so that safety problems can be recognised. The review also challenges professional and organisational defensiveness. Patients' experiences should inform safety surveillance and service improvement, rather than be discounted because a treatment is established or initially considered successful. Read document

N16 Paterson Inquiry (2020)

England | Independent inquiry

The Paterson inquiry examined how a surgeon's harmful practice continued across NHS and independent hospitals. It identified weaknesses in clinical scrutiny, consent, information sharing and organisational responses to concerns, rather than treating the case solely as the misconduct of one individual.

Patients need accurate explanations of their condition, the proposed treatment and alternatives, with genuine opportunities to question recommendations. Multidisciplinary discussion must provide meaningful challenge and should not become a formality dominated by one clinician. Practice patterns and outcomes require monitoring across every setting in which a clinician works.

The recommendations called for stronger oversight, more effective multidisciplinary working, better information for patients and clearer responsibilities across providers. Concerns about an influential or successful colleague must still be investigated. The report highlights the danger of gaps between organisations: responsibility for patient safety cannot be allowed to disappear when care crosses NHS and independent-sector boundaries. Read document

N17 Infected Blood Inquiry report (2024)

UK | Public inquiry

The Infected Blood Inquiry examined how people were infected with HIV and hepatitis through blood and blood products, and how institutions subsequently responded. It concluded that patient safety was not consistently prioritised, risks were inadequately addressed and failures in information and consent compounded the harm.

The report describes institutional defensiveness, concealment and delay. It argues that waiting for certainty can obstruct precautionary action when evidence of a serious risk is emerging. Clear decision-making, honest records and timely sharing of information are therefore central to its lessons.

N17 Infected Blood Inquiry report (2024)

UK | Public inquiry

Recommendations include compensation and recognition for those affected, incorporating the inquiry's lessons into professional education and strengthening safety and accountability. The report also stresses the need to learn systematically from harm rather than assume that later improvements make further examination unnecessary. Its relevance extends beyond transfusion: it concerns how clinicians, organisations and government respond when treatment may be causing harm and when patients seek answers. Read document

N18 Martha's Rule: core standards

England | Deterioration and escalation

Martha's Rule strengthens the recognition and response to deterioration when patients, families, carers or staff believe that concerns have not been adequately addressed. Its three components are a routinely asked patient wellness question, access to escalation, and rapid review by an appropriately skilled clinician independent of the immediate care team.

The core standards require these components to be reliable and accessible, with patients' and families' own observations recorded and acted upon. People must understand how to request help; language, disability, confidence or lack of digital access should not prevent them from using the process.

Staff need training in recognising concerns, facilitating review and communicating the outcome. Organisations should integrate Martha's Rule with existing deterioration systems, governance and improvement work, using activation data and feedback to identify problems. It supplements normal clinical listening and escalation: families should not need to invoke a special process before their concerns receive attention. Read document

N19 Workforce Race Equality Standard (WRES)

England | Workforce equality indicators

WRES uses nine indicators to help NHS organisations identify racial inequalities in employment and staff experience. It examines matters such as representation, recruitment from shortlisting, entry into disciplinary processes, access to development and staff reports of bullying, discrimination and career opportunity.

The purpose is to make differences visible and support accountable local improvement. A workforce may be diverse overall while minority ethnic staff remain underrepresented in senior positions or experience less favourable treatment. Recruitment and promotion figures should therefore be considered alongside staff experience and the way organisational processes operate.

The standard supports action based on evidence rather than assumptions. Organisations need to understand the reasons for disparities, involve staff in developing responses and assess whether changes improve fairness. Reporting data is only the starting point; improvements depend on recruitment practice, allocation of opportunity, proportionate employee-relations processes and a workplace in which concerns can be raised safely. Read document

N20 Workforce Disability Equality Standard (WDES)

England | Workforce equality indicators

WDES uses ten metrics to examine the employment experiences of disabled NHS staff. It draws on workforce information, recruitment data and staff survey results, covering representation, access to opportunity, workplace treatment, feeling valued and the support required to work effectively.

The standard recognises that disabled staff can face barriers not apparent from headline staffing figures. Relevant issues include accessible recruitment, suitable adjustments, pressure to work when unwell, bullying or harassment and whether staff feel able to participate fully in their organisation.

Organisations should combine the data with disabled staff's experiences to identify and remove barriers. Disclosure must be handled sensitively, and low disclosure rates should not automatically be interpreted as evidence that few staff need support. Effective improvement means timely, usable adjustments, fair access to development and evidence that staff experience has changed, rather than simply publishing a policy or collecting the metrics. Read document

N21 Shared decision making (NICE NG197)

England-focused guidance | Patient involvement

NICE NG197 describes shared decision making as a joint process that combines clinical evidence with the person's preferences, values and circumstances. It applies to decisions about investigations and treatment, including the option of no treatment or no change where appropriate.

Clinicians should explain options, benefits, harms and uncertainty in understandable terms, explore what matters to the person and check understanding. Decision aids and clear numerical risk information can support the discussion, but should not replace it. People may need additional time, accessible information or support from someone they trust to participate meaningfully.

The guidance also addresses the organisational conditions that make shared decisions possible: staff skills, suitable information and processes that support continuity. Agreed decisions should be recorded and revisited when circumstances or preferences change. Its emphasis is not simply obtaining consent to a professional recommendation, but helping the person make an informed choice between reasonable options. Read document

N22 A cyber-resilient health and adult social care system: strategy to 2030

England | Digital resilience

This strategy treats cyber resilience as a patient-safety and service-continuity issue, not merely an IT responsibility. Loss of access to records, diagnostics, prescribing or operational systems can disrupt care even when no information has been stolen.

Its five pillars are focusing on the greatest risks and harms, defending as one, developing people and culture, building secure technology, and exemplary response and recovery. The approach recognises the interdependence of hospitals, primary care, social care and suppliers: a weakness in one part of the system can affect others.

Organisations need to understand their critical services and dependencies, apply proportionate safeguards, develop workforce awareness and rehearse how to maintain essential care during disruption. Security should be built into technology and procurement decisions. Recovery plans, clear responsibilities and shared learning from incidents are as important as preventing an attack in the first place. Read document

N23 NHS Green Plan guidance

England | Environmental sustainability

NHS Green Plans translate national environmental commitments into local delivery. The guidance asks organisations to set out practical priorities, accountable leadership and measurable actions, with plans approved by the board or governing body and made publicly available.

The scope includes clinical pathways, medicines, travel, estates and energy, procurement, food and waste, alongside preparation for the effects of climate change. Clinical services can contribute through prevention, appropriate treatment, avoiding unnecessary activity and reducing resource-intensive practices where safe alternatives exist.

The guidance links sustainability with high-quality care and efficient use of resources rather than treating it as a separate environmental project. Delivery requires staff engagement and cooperation across clinical, operational and estates teams. Actions need realistic implementation arrangements and monitoring so that organisations can demonstrate reduced waste and environmental impact while maintaining patient safety, access and quality. Read document

N24 The Leng review of physician associate and anaesthesia associate roles (2025)

England-focused review | Workforce roles

The 2025 Leng review concluded that physician associate and anaesthesia associate roles should neither be abolished nor continue unchanged. It identified concerns about role clarity, safety, supervision and the way these professions had been introduced into clinical teams.

Recommendations included renaming physician associates as physician assistants and anaesthesia associates as physician assistants in anaesthesia, clearer identification to patients, formal credentialling and defined career development. Physician assistants should not see undifferentiated patients except within nationally defined clinical protocols. The review also recommended at least two years in secondary care before newly qualified physician assistants move into primary care or mental health services.

N24 The Leng review of physician associate and anaesthesia associate roles (2025)

England-focused review | Workforce roles

Teams should have explicit responsibilities and accountability, with a named doctor providing formal supervision. Anaesthesia roles should remain within the relevant scope-of-practice boundaries. The review presents these as recommendations for safe deployment and professional development; proposed changes to titles or future responsibilities should not be confused with permissions already in force. Read document

S01 GIRFT: Acute and general medicine

England | 2022 national review; public report page

The 2022 GIRFT review examines how acute and general medicine can provide timely assessment and avoid unnecessary or prolonged hospital care. It identifies inconsistent service organisation, terminology and recording of activity as barriers to comparing services and understanding where delays arise.

Its recommendations emphasise clear patient pathways, appropriate early assessment and multidisciplinary staffing matched to demand. The location and organisation of acute services should support effective handovers and access to investigations and other specialties. Older people and patients with frailty require care that recognises their broader needs, rather than an approach focused only on the immediate presenting illness.

The review also highlights the importance of accurate diagnosis and coding, including avoiding overdiagnosis of sepsis. Its central message is that better flow depends on coordinated clinical processes and reliable information, not simply on providing more beds. Standardised definitions and meaningful data are necessary to distinguish genuine differences in performance from differences in how activity is recorded. Read document

S02 GIRFT: Dermatology

England | 2021 national review; public report page

The dermatology review addresses variation in access to specialist care and the pressures created by workforce shortages and rising demand. It links timely diagnosis and treatment with the recruitment and retention of a sustainable multidisciplinary workforce.

Recommendations include better use of specialist nurses, support and training for clinicians outside hospital, and pathways that direct patients to the right level of expertise. Teledermatology can help with referral assessment and advice, but the clinical question, image quality and need for examination must determine whether remote care is appropriate.

Skin cancer care is a particular service priority. Clear arrangements for outpatient procedures and day-case surgery can improve use of capacity and reduce unnecessary hospital contacts. Overall, the report supports coordinated referral, investigation and treatment pathways rather than simply increasing appointment numbers. Technology and changes in skill mix are intended to improve access while preserving diagnostic quality and continuity. Read document

S03 GIRFT: Endocrinology

England | 2021 national review; public report page

The endocrinology review examines variation in specialist investigation, outpatient care and endocrine surgery. One of its principal recommendations is to concentrate thyroid, parathyroid, adrenal and pituitary surgery in appropriately experienced hands, with specialist teams and pathways supporting complex decisions.

It identifies opportunities to make outpatient care more useful and efficient. Completing appropriate tests before an appointment allows the consultation to move towards a diagnosis or treatment decision, rather than generating another avoidable visit. Selected follow-up can be delivered remotely, while endocrine specialist nurses can strengthen continuity, education and multidisciplinary care.

The report also draws attention to incomplete recording of endocrine activity, which can obscure demand and undermine service planning. Better coding and information are therefore part of the improvement programme. The overall emphasis is on matching specialist expertise to patient need, coordinating medical and surgical services, and organising appointments around meaningful clinical progress rather than repeated contacts. Read document

S04 GIRFT: Gastroenterology

England | 2021 national review; public report page

The gastroenterology review examines how services can improve access and reduce unnecessary admissions and appointments. It identifies the organisation of diagnostic and outpatient pathways, including endoscopy, as an important source of variation between hospitals.

Recommendations include extending the availability of endoscopy across the week where appropriate, improving triage and working more closely with primary care. Investigations and specialist assessment should be coordinated so that patients do not move through repeated appointments without a clear diagnostic or treatment plan.

The report also favours proactive care for long-term conditions such as inflammatory bowel disease. Reliable access to specialist advice can allow deterioration to be recognised and treated before emergency admission becomes necessary. The central service challenge is to match capacity to clinical need while maintaining rapid access for higher-risk patients. Efficient pathways should reduce avoidable contacts and delays, rather than simply transfer work elsewhere or restrict access to specialist care. Read document

S05 GIRFT: Geriatric medicine

England | 2021 national review; public report page

The geriatric medicine review argues for care organised around the needs of older people and people living with frailty, rather than around individual hospital episodes. Effective services require cooperation between primary care, hospitals, community teams, care homes, local authorities and voluntary organisations.

Its recommendations emphasise identifying frailty, anticipating deterioration and providing coordinated support that can prevent avoidable admissions. Once someone is in hospital, care should protect mobility, function and independence. Delirium, deconditioning and poorly coordinated discharge can worsen outcomes even when the presenting illness has been treated successfully.

The report supports population-based planning, multidisciplinary working and better information sharing across organisational boundaries. Care closer to home is valuable when the necessary support and clinical oversight are available. The important outcomes extend beyond bed occupancy or length of stay: maintaining function, reducing avoidable harm and achieving a sustainable discharge are central to a successful pathway. Read document

S06 GIRFT: Hospital dentistry

England | 2021 national review; public report page

The hospital dentistry review examines how patients reach the appropriate dental service and how specialist capacity can be used more effectively. It highlights the burden of preventable dental disease, including children needing extractions, and connects hospital demand with prevention and access to community dental care.

Recommendations include clearer referral and triage arrangements, better use of primary and intermediate-level services for suitable procedures, and reliable access to hospital expertise for complex patients. Managed clinical networks and operational delivery networks can help coordinate provision, including children's dental surgery.

The report also emphasises workforce planning and more accurate coding and activity information. Without these, it is difficult to establish demand, compare services or plan capacity. Its overall approach is to reduce unnecessary hospital treatment while protecting specialist care for patients who genuinely need it. Prevention, appropriate setting and coordination between providers are therefore as important as efficiency within the hospital clinic or theatre. Read document

S07 GIRFT: Children and young people's mental health

England | 2022 national review; public report page

The 2022 review of children and young people's mental health services considers community, crisis and inpatient care as parts of one pathway. It identifies the importance of strengthening intensive community support so that admission is used when clinically necessary, rather than because an alternative is unavailable.

Recommendations include involving acute hospitals in crisis pathways, improving coordination across services and reducing unnecessary or prolonged stays in general adolescent units. Young people with autism or learning disabilities need provision that responds to their particular needs rather than relying on an unsuitable generic pathway.

S07 GIRFT: Children and young people's mental health

England | 2022 national review; public report page

The report's wider message is that inpatient capacity cannot be planned in isolation from community provision and other agencies. Clear responsibility is needed when mental health services, paediatrics, social care and education are involved. The intended improvements are more appropriate care, better continuity and support closer to home, with the young person and family involved in planning rather than left to negotiate disconnected services. Read document

S08 GIRFT: Neurology

England | 2021 national review; public report page

The neurology review identifies significant variation in access to neurological expertise, affecting both hospital inpatients and people referred to outpatient services. Differences in regional organisation and historical funding can mean that access depends too heavily on where a patient lives.

The report recommends planning services around population need and using regional networks to share specialist expertise more effectively. Care closer to home should be supported by reliable access to specialist advice, investigations and onward referral, rather than leaving local teams without the help needed to manage complex conditions.

Improving access requires attention to the whole pathway: urgent advice, inpatient review, outpatient assessment and continuing care. The report also supports better use of information and shared good practice to identify unwarranted variation. Its principal concern is equitable access to appropriate expertise and continuity across the network, not a requirement that every hospital provide every neurological subspecialty independently. Read document

S09 GIRFT: Pathology

England | 2021 national review; public report page

The pathology review treats diagnostics as an end-to-end clinical pathway rather than simply a laboratory production process. Its CLEAN framework focuses attention on choosing the appropriate test, obtaining and processing the right specimen, communicating a reliable result and ensuring that the result is understood and acted upon.

This approach makes the stages before and after laboratory analysis as important as turnaround time within the laboratory. Unnecessary requests, poor specimen quality, delayed communication or a failure to act on an abnormal result can all reduce the value of testing and expose patients to harm.

The report recommends coordinated improvement across clinical and laboratory teams, supported by networks, better information and appropriate standardisation. Efficiency should be assessed alongside diagnostic quality and the effect on patient care, rather than through test price alone. Better demand management and dependable communication are therefore central to using pathology capacity well and improving the clinical usefulness of investigations. Read document

S10 GIRFT: Renal medicine

England | 2021 national review; public report page

The renal medicine review considers variation across kidney care, including dialysis, transplantation, acute kidney injury and specialist outpatient services. It recommends improving equitable access to transplantation and ensuring that suitable patients can consider home dialysis with appropriate practical support.

The review also calls for more timely specialist involvement and transfer for patients with acute kidney injury. Coordinated vascular access services are important to reliable dialysis provision. Specialist pathways, including renal disease in pregnancy and vasculitis, should connect patients with the expertise required for complex care.

Outpatient services can reduce unnecessary face-to-face visits where remote follow-up is clinically appropriate, but treatment and follow-up arrangements must reflect individual circumstances. The report's main themes are timely access, meaningful treatment choice and coordination across the renal pathway. Home treatment or fewer hospital visits should improve patients' lives and outcomes, rather than simply shift responsibility or costs from the service to patients and families. Read document

S11 GIRFT: Respiratory medicine

England | 2021 national review; public report page

The respiratory review addresses variation in care for common and serious respiratory conditions, including asthma, COPD, pneumonia and pleural disease. It links clinical outcomes with the availability of appropriately staffed specialist services and dependable pathways.

A key recommendation is to provide non-invasive ventilation in a suitable environment with the necessary expertise, equipment and monitoring. Respiratory support units can strengthen care for patients who need more support than an ordinary ward can provide but do not necessarily require intensive care.

The report also emphasises organising capacity around predictable changes in demand, including winter pressures, rather than relying on repeated emergency responses. Specialist teams need to work with emergency, acute medical and community services so that assessment, treatment and discharge form a coherent pathway. The overall objective is timely, reliable respiratory care with the right level of support, reducing unwarranted variation without assuming that all patients need the same setting or intensity of treatment. Read document

S12 GIRFT: Rheumatology

England | 2021 national review; public report page

The rheumatology review focuses on matching specialist capacity to clinical need and reducing unwarranted variation in access and care. It distinguishes patients with complex inflammatory disease, who need timely specialist input, from people whose non-inflammatory musculoskeletal problems may be better supported through an appropriate community pathway.

Osteoarthritis, fibromyalgia and other persistent pain presentations require effective care, but routinely routing all such patients through hospital rheumatology can delay access for those needing specialist assessment. The report therefore supports clearer referral arrangements and cooperation with primary care and other musculoskeletal services.

It also identifies opportunities to avoid unnecessary follow-up and to use treatments and resources more effectively. Decisions about appointments and medicines should be based on clinical need, safety and value. The overall aim is not simply to reduce referrals: it is to provide a dependable alternative where appropriate and preserve specialist capacity for patients who benefit most from it. Read document

S13 GIRFT: Cardiothoracic surgery

England | 2018 national review; public report page

The 2018 cardiothoracic surgery review identifies opportunities to improve outcomes and reduce delays through better organisation of specialist services. Its recommendations address variation in cardiac and thoracic pathways, including lung cancer, aortic surgery and mitral valve repair.

A major theme is patient flow. Better bed management, admission on the day of surgery where appropriate, and protected access to intensive care and ward beds can reduce avoidable cancellations and prolonged stays. The report also supports appropriate use of less-invasive thoracic procedures, including video-assisted thoracoscopic surgery.

Designated specialist multidisciplinary teams should support decisions for key procedures, with expertise matched to the complexity of care. Improved clinical coding and use of national outcome data are needed to benchmark performance and investigate adverse outcomes. The report therefore connects surgical quality with the supporting system: beds, specialist teams, information and dependable pathways all influence whether patients receive timely and effective treatment. Read document

S14 GIRFT: Cranial neurosurgery

England | 2020 national review; public report page

The cranial neurosurgery review examines how patients can receive specialist treatment sooner while making better use of operating theatres, beds and surgical expertise. It identifies unnecessary admissions and prolonged stays, including time in critical care, as opportunities for improvement.

Recommendations include streamlining the pathway from admission to surgery, using critical care according to clinical need and drawing on experienced surgeons for appropriate specialist procedures. Better procurement and more consistent organisation of care can release resources without reducing the quality of treatment.

S14 GIRFT: Cranial neurosurgery

England | 2020 national review; public report page

The report also highlights limitations in available information: some datasets combine cranial and other neurosurgical activity, and useful outcome measures are not consistently available. Improving coding and clinically meaningful metrics is therefore necessary for reliable comparison. The main objective is a more efficient pathway that protects patients from the risks of delay, while judging success through outcomes and experience rather than bed use alone. Read document

S15 GIRFT: Ear, nose and throat surgery

England | 2019 national review; public report page

The ENT review identifies opportunities to reduce avoidable overnight stays, admissions and repeated outpatient visits. A central recommendation is to increase day-case surgery for suitable patients, drawing on units that already achieve higher rates safely.

Better day-case pathways can make services less vulnerable to inpatient bed shortages and allow more patients to receive treatment without an unnecessary hospital stay. This requires appropriate patient selection, preparation, theatre organisation and clear arrangements for recovery and discharge, rather than simply changing an admission label.

The broader aim is to organise care so that patients progress through assessment, investigation and treatment with fewer avoidable delays or contacts. Comparing practice between units helps identify variation that may be reduced through better processes. The report links improved patient experience with more effective use of capacity: shorter stays and fewer visits are valuable when they preserve clinical quality and provide a reliable route to further help when required. Read document

S16 GIRFT: General surgery: national review and follow-up

England | 2017 review and subsequent follow-up national review; public report page

GIRFT's general surgery review examines opportunities to improve both emergency and elective pathways. One prominent recommendation is consultant-led assessment at the hospital's front door, allowing earlier diagnosis and decisions about who needs admission, surgery or a suitable alternative pathway.

The report identifies scope to reduce emergency admissions that do not lead to an operation and to increase appropriate day-case provision. Better organisation of perioperative care and discharge can shorten unnecessary hospital stays and release capacity without relying solely on additional beds.

National audit and activity data are used to identify variation in practice and outcomes. The follow-up work considers progress after the original review rather than assuming its baseline still represents current performance. The recurring themes are early experienced decision-making, clear pathways and consistent delivery of evidence-based care. Improvements should reduce avoidable delays and complications as well as improve efficiency, particularly for patients with substantial perioperative risk. Read document

S17 GIRFT: Ophthalmology

England | 2019 national review; public report page

The ophthalmology review addresses a high-volume service in which delayed assessment, treatment or follow-up can lead to avoidable sight loss. It covers the organisation of core services, including cataract, glaucoma, age-related macular degeneration and diabetic eye disease.

Recommendations focus on releasing capacity through more efficient pathways and better use of the wider multidisciplinary team, reducing unnecessary reliance on consultant-delivered care. Cataract surgery is a major example: improved theatre organisation can allow more suitable patients to be treated promptly while maintaining quality and appropriate selection.

The report's purpose is not simply to increase surgical throughput. Reliable monitoring and follow-up for long-term eye disease are equally important to protecting vision. Capacity should therefore be planned across assessment, treatment and continuing care. Greater efficiency, appropriate delegation and comparison of outcomes are intended to improve timely access and reduce the risk that patients deteriorate while waiting for an appointment. Read document

S18 GIRFT: Oral and maxillofacial surgery

England | 2018 and subsequent network guidance national review; public report page

The oral and maxillofacial surgery review recommends organising services through effective hub-and-spoke networks. More complex work, particularly head and neck cancer and orthognathic surgery, should have access to the appropriate concentration of expertise and supporting facilities.

At the same time, the report questions why some simpler procedures, such as suitable wisdom tooth extractions, continue to be undertaken in hospital when an appropriate alternative setting may be available. Better referral and triage arrangements can preserve hospital capacity for patients whose complexity requires it.

Subsequent network guidance explains how specialist inpatient services can connect with outpatient and day-case activity across sites. Clear responsibilities, referral routes and continuity are essential to avoid fragmentation. The overall aim is shorter waits, fewer unnecessary admissions and visits, and more consistent quality. Network development should combine access to specialist expertise with care closer to home where this is clinically appropriate. Read document

S19 GIRFT: Orthopaedic surgery

England | Foundational national review and follow-up national review; public report page

The original orthopaedic GIRFT review identified unwarranted variation in surgical practice, implant use, complications and costs. It established the approach of comparing national data with detailed clinical discussion to understand why apparently similar services achieve different results.

Its improvement themes include appropriate implant selection and procurement, protected elective capacity, reducing infection and revision surgery, and concentrating complex work where expertise and supporting services are available. Length of stay is considered alongside preparation, recovery and discharge rather than as an isolated target.

The 2020 follow-up reported progress in several areas, including shorter stays and lower revision and infection rates. These are historical findings, not a statement of every unit's current performance. The underlying message is that better quality can also reduce avoidable cost: preventing complications and repeat surgery releases capacity more meaningfully than focusing only on the price of an implant or the number of operations performed. Read document

S20 GIRFT: Paediatric general surgery and urology

England | National specialty review national review; public report page

The paediatric general surgery and urology review recommends a network model that puts the right expertise in the right place for each child. Rare and highly complex operations should be concentrated in fewer specialist centres, while appropriate local provision remains important for more common conditions.

The review also considers how hospitals manage everyday surgical problems such as appendicitis. Consistent assessment, referral and treatment pathways should help children receive timely care without unnecessary transfer or avoidable delay. The capabilities of anaesthesia, paediatrics, radiology, intensive care and other supporting services influence where surgery can be delivered safely.

Its central theme is that concentration of expertise and accessible local care are complementary, not competing, objectives. Networks need dependable arrangements for advice, transfer and follow-up so that families experience a coherent service. Service design should reflect children's clinical needs and the required supporting workforce rather than simply reproduce adult surgical arrangements. Read document

S21 GIRFT: Plastic surgery, hand surgery and burns

England | National specialty review national review; public report page

The plastic surgery, hand surgery and burn care review focuses on variation in access and the organisation of services spanning a wide range of reconstructive and emergency work. It recognises that these services already operate through extensive hub-and-spoke arrangements, with hand surgery shared between plastic and orthopaedic teams.

A principal recommendation is a more consistent national approach to elective referral, reducing differences in access that arise from local arrangements rather than clinical need. The report also calls for better representation of these services in national information and planning systems, so that activity and demand are understood more accurately.

S21 GIRFT: Plastic surgery, hand surgery and burns

England | National specialty review national review; public report page

Meaningful outcome and service measures are needed to support comparison and quality improvement. Because of the breadth of the specialty, the report concentrates on organisational issues rather than prescribing every subspecialty pathway. Its main priorities are equitable access, clearer service organisation and better data, providing a foundation for more detailed work on individual reconstructive, hand and burn pathways. Read document

S22 GIRFT: Urology

England | 2018 and subsequent pathway material national review; public report page

The urology review recommends shifting suitable care towards dedicated urological investigation units, outpatient services and day surgery. These arrangements can reduce avoidable admissions and repeated visits while preserving inpatient capacity for patients who need it.

A central workforce recommendation is to develop specialist nursing roles within well-organised services. This can improve continuity and free consultants to provide experienced decision-making in emergency urology. Urinary retention and stone disease are examples where a more definitive diagnosis and treatment plan can prevent repeated presentations or prolonged waits.

The report therefore links outpatient redesign with stronger emergency provision rather than treating them as separate problems. Its priorities are timely investigation, appropriate treatment settings and clear clinical ownership. Success depends on patients reaching a definitive plan, not merely having fewer appointments. Subsequent GIRFT pathway resources develop these principles for particular urological conditions and procedures. Read document

S23 GIRFT: Vascular surgery

England | National specialty review national review; public report page

The vascular surgery review recommends fully developed hub-and-spoke networks to provide dependable access to specialist assessment and intervention. The aim is round-the-clock availability of diagnostic services, experienced decision-makers and timely treatment for urgent vascular conditions.

Better network organisation should reduce delays for patients at risk of stroke, aneurysm rupture or limb loss. It also supports more effective use of surgical resources, shorter unnecessary stays and fewer readmissions. Referral and transfer arrangements are therefore central to the model, rather than peripheral administrative details.

The report connects specialist concentration with access across the whole network. A hub must be supported by clear pathways from referring hospitals and appropriate arrangements for subsequent care. The key service priorities are speed, reliability and continuity, supported by meaningful outcome information. Simply naming a network is insufficient unless patients can actually reach the required expertise, imaging and intervention when they need them. Read document

S24 GIRFT: Mental health rehabilitation

England | 2022 national review; public report page

The mental health rehabilitation review examines services for people with severe and complex mental illness, particularly psychosis. It recommends a whole-system rehabilitation pathway that joins specialist inpatient treatment with community support and suitable accommodation.

Reducing avoidable out-of-provider placements and providing care closer to home are important priorities. Long stays or distant placements can weaken relationships and continuity, while discharge without adequate support may not be sustainable. A skilled multidisciplinary workforce is needed to help people develop the capabilities and support required for recovery.

The report emphasises standardising pathways and coordinating health, social care and housing provision. The desired result is successful, sustained progression through rehabilitation, not discharge alone. Planning must therefore address the practical barriers that keep people in hospital or prevent them returning to local services, with patients and carers involved in decisions about their needs, goals and future support. Read document

S25 GIRFT: Emergency medicine

England | 2021 national review; public report page

The emergency medicine review analyses the relationship between demand, capacity, patient flow and outcomes. It argues that departments and their wider organisations need reliable information about the needs of their catchment population before deciding how services should change.

Its Summary ED Indicator Table brings together measures that help identify where pathways are failing. This allows teams to distinguish high demand from inadequate capacity, internal process delays or problems accessing other hospital and community services. Emergency department performance cannot be understood in isolation from the rest of the system.

The report supports data-led service planning and practical changes that improve timely care and safe discharge. A single waiting-time measure cannot describe all aspects of emergency care quality. The wider priorities are appropriate assessment, reduced avoidable delay and reliable onward care, with capacity and workforce arrangements matched to the pattern of demand rather than based only on historical provision. Read document

S26 GPAS: The Good Department (2025)

UK | Anaesthetic service standards

The Good Department chapter of GPAS describes the organisational foundations of a safe, high-quality anaesthetic service. It covers leadership and strategy, workforce, education, clinical governance and support services, rather than individual anaesthetic techniques.

Recommendations include an explicit patient-centred safety culture, inclusive two-way communication and a management structure that supports improvement. Staffing, job plans, supervision and rotas should reflect service needs while addressing fatigue, wellbeing and negative behaviour. Induction, continuing education and multidisciplinary simulation are part of maintaining a capable team.

Clinical governance should link incident reporting, complaints, patient feedback and risk management to demonstrable learning. Departments also need reliable equipment, records, administrative support and facilities. The chapter makes clear that staff wellbeing and professional relationships are not separate from clinical quality: they help create the conditions in which colleagues can speak up, remain in the service and contribute effectively to safe care. Read document

S27 Guidelines for the Provision of Intensive Care Services, version 3 (2026)

UK | Adult intensive care standards

GPICS version 3 provides the UK framework for planning, commissioning and delivering adult intensive care. Its five sections cover service structure, workforce, clinical care, service development and preparedness, incorporating lessons from the pandemic and subsequent changes in practice.

The document distinguishes minimum standards, which all UK intensive care units are expected to meet, from recommendations describing a higher-quality service. This distinction supports clear discussion of essential provision rather than treating every desirable improvement as an identical requirement.

The framework brings together the organisation, staffing and supporting systems needed for dependable intensive care, including preparation for disruption or increased demand. An accompanying audit tool helps units assess implementation, identify gaps and monitor improvement. The central message is that intensive care quality depends on a complete service model, not simply bed numbers or individual clinical expertise. Standards provide a basis for local assurance and planning, with shortfalls requiring explicit attention rather than informal acceptance. Read document

S28 Facing the Future: standards for acute general paediatric services

UK | Acute paediatric service standards

Facing the Future sets standards for the organisation of acute general paediatric services. Its central principle is that children should have timely access to professionals with the necessary competencies, including senior review and advice throughout the acute pathway.

The standards specify consultant presence during peak activity, seven days a week. Children admitted with an acute medical problem should be reviewed by a tier-two competent professional within four hours and by a consultant within 14 hours, sooner when severity or staff concern requires it. At least two medical handovers in each 24-hour period should be consultant-led.

S28 Facing the Future: standards for acute general paediatric services

UK | Acute paediatric service standards

The document also requires appropriate senior involvement before discharge and access to consultant advice for paediatric assessment units. These arrangements are intended to improve decision-making, continuity and the reliability of escalation. The times are maximum service standards, not permission to delay an urgent review: an unwell child or a concerned colleague may require immediate senior assessment. Read document

S29 NCISH Annual Report 2026: UK patient and population data, 2013-2023

UK and Jersey | Mental health safety

The 2026 NCISH report examines suicides among people in contact with mental health services, using comprehensive data through 2023. It highlights the continuing importance of social adversity, self-harm, substance misuse and continuity of care, alongside particular concerns in crisis services and the period after inpatient discharge.

Recommendations emphasise safer inpatient environments and follow-up that anticipates deterioration rather than merely records a completed contact. Changing patterns of inpatient deaths require attention to ligatures even where fixed ligature points have been removed. Crisis teams need to assess how well they support people with depression, recent self-harm, a short illness history and limited social support.

The report also draws attention to people aged 75 and over, patients with anxiety disorders and recent migrants. Depression, physical illness, isolation, bereavement and housing or financial difficulties require active consideration. Its message is to tailor prevention and coordinated care to the person's clinical and social circumstances, rather than assume that the absence of conventional risk factors means little risk. Read document

S30 Rehabilitation after traumatic injury (NICE NG211)

England-focused guidance | Rehabilitation pathway

NICE NG211 describes rehabilitation for people with complex needs following traumatic injury. Assessment should consider physical, cognitive and psychological problems, as well as the person's home circumstances, relationships and meaningful activities.

The multidisciplinary team should agree individual goals with the person and, where appropriate, their family or carers. These should be brought together in one accessible rehabilitation plan, identifying interventions, responsibilities, follow-up and the professional coordinating care. The plan should be shared with the relevant teams and updated as needs and goals change.

The guideline emphasises planning transitions early, particularly discharge from hospital to community rehabilitation. Equipment, information, support and referrals should be arranged rather than left for the patient to coordinate. Return to work, education, leisure and driving may require specific advice. The overall objective is a continuous, personalised rehabilitation pathway that helps the person regain participation and independence, not simply completion of acute treatment. Read document

S31 Hearing loss in adults: assessment and management (NICE NG98)

England-focused guidance | Adult hearing services

NICE NG98 covers assessment and management of adult hearing loss. It distinguishes presentations requiring urgent specialist referral from routine audiological assessment and emphasises the effects of hearing loss on communication and everyday life, not just the audiogram.

Assessment and management should take account of personal goals, preferences and practical needs, including cognition, dexterity and mobility. Hearing aids, other devices and communication strategies should be explained and incorporated into a personalised plan. The choice of support should reflect what the person needs to do in daily life.

After hearing aids are fitted, the guideline recommends follow-up at six to twelve weeks, with remote contact available when preferred. Review should address comfort, use, maintenance, settings and whether the agreed goals have been achieved. Patients also need clear access to repairs, adjustments and reassessment. Providing a device is therefore the start of continuing support rather than the endpoint of care. Read document

S32 SEQOHS standards (2023)

UK | Occupational health quality standards

The 2023 SEQOHS standards define a quality framework for occupational health services. They place greater emphasis on outputs and outcomes, asking providers to demonstrate that they understand and meet the needs of client organisations and employees, rather than merely maintain documented processes.

The six domains cover governance and finance; resources and processes; outputs and outcomes; information and communication; quality assurance and improvement; and additional NHS requirements. The framework therefore connects the organisation of the service with the usefulness and impact of its advice.

The supporting evidence guide clarifies how providers demonstrate compliance with health and safety, data protection and equality requirements. Accreditation requires evidence of the standards in everyday delivery. The principal message is that an occupational health service should be able to show both reliable professional processes and meaningful value: appropriate advice, effective communication and improvement that responds to the needs of the people and organisations using it. Read document

S33 CAA aeromedical certification overview

UK | Aviation medical framework

The CAA overview explains the different medical certification routes for aviation roles. Commercial pilots generally require Class 1 certification, private pilots normally use Class 2 or an applicable alternative, and air traffic controllers require Class 3. Light aircraft and some other operations have separate provisions.

The applicable route depends on the privileges being exercised, not simply on whether a person considers themselves medically fit. Certain eligible pilots may use a medical declaration, subject to conditions and operational restrictions. This is not interchangeable with every category of medical certificate.

Applications normally involve the CAA's medical records system and an appropriately certificated aeromedical examiner. Initial Class 1 and Class 3 examinations are undertaken at an aeromedical centre. The overview also advises applicants to establish that they meet the relevant medical requirements before committing to substantial training. Its central issue is matching assessment and certification to the specific aviation role and the risks associated with it. Read document

S34 ARSAC Notes for Guidance (July 2026)

UK | Nuclear medicine guidance

The ARSAC Notes for Guidance set out good clinical practice for the administration of radiopharmaceuticals and the use of sealed radioactive sources in diagnosis, treatment and research. They combine specialist clinical guidance with the licensing arrangements needed for nuclear medicine practice.

The document addresses appropriate authorisation, professional expertise and the responsibilities supporting safe service delivery. Employer and practitioner licensing must cover the relevant activity; a general qualification or access to equipment does not by itself establish permission to undertake every nuclear medicine procedure.

The notes also guide the appropriate use of radioactive substances, with attention to radiation protection and the circumstances of the patient or research participant. They sit alongside radiation legislation and local procedures rather than replacing them. The July 2026 edition includes an account of changes from the previous version. The central service requirement is to connect clinical justification and specialist competence with the correct authorisation, facilities and governance. Read document

S35 Genome UK: the future of healthcare

UK | Genomic healthcare strategy

Genome UK sets a ten-year vision for using genomics to improve healthcare and research. Its three pillars are diagnosis and personalised medicine, prevention, and research. The strategy seeks earlier and more accurate diagnosis, better understanding of risk and treatments tailored to the individual.

Priorities include integrating genomic testing into routine care, developing pharmacogenomics and combining genomic information with other clinical data in cancer care. Research and clinical services should work together so that discoveries can translate into practical benefits for patients.

S35 Genome UK: the future of healthcare

UK | Genomic healthcare strategy

Delivery depends on more than sequencing technology. The strategy addresses workforce skills, data infrastructure, collaboration and public confidence, including privacy and responsible use of information. Diversity in research and equitable access are important because benefits should not be restricted to well-represented populations or particular locations. The overall aim is a connected genomic healthcare system in which testing is linked to interpretation, informed decisions and an appropriate care pathway. Read document

S36 Good Clinical Practice: HRA guidance

UK | Research quality and ethics

The HRA describes Good Clinical Practice as the ethical and scientific quality requirements underpinning the design, conduct, recording and reporting of clinical trials involving people. The central purposes are protection of participants' rights, safety and wellbeing, and production of reliable research information.

The guidance supports a proportionate approach to implementation and staff training. People undertaking research tasks, including obtaining consent, need education, experience and competence appropriate to their responsibilities. Completing a generic course is not a substitute for understanding the study and the duties attached to a particular role.

Requirements differ between types of research. The guidance distinguishes medicinal-product trials, device investigations and other studies, while maintaining that all research must protect participants and produce trustworthy data. It links to ICH and MHRA material for the detailed standards and inspection framework. The key distinction is between the underlying ethical and quality principles and the specific legal or procedural requirements applying to an individual study. Read document

S37 Confronting antimicrobial resistance 2024 to 2029

UK | Antimicrobial resistance action plan

The UK's antimicrobial resistance action plan for 2024-2029 uses a One Health approach, recognising that resistance connects human health, animals, food and the environment. It is part of the longer-term ambition to contain and control antimicrobial resistance by 2040.

Four themes organise the plan: reducing the need for and unintended exposure to antimicrobials; optimising their use; investing in innovation, supply and access; and acting as a responsible global partner. Infection prevention, vaccination and effective care reduce demand for treatment, while stewardship and diagnostics support appropriate prescribing and review.

Surveillance and research are needed to track resistance and improve interventions. The plan also recognises that new medicines and diagnostics must be developed, supplied and accessible, rather than relying only on conserving existing treatments. Its main message is that resistance cannot be addressed through prescribing targets alone: prevention, high-quality treatment, innovation and international cooperation must work together across sectors. Read document

S38 UK Chief Medical Officers' physical activity guidelines (2026 refresh)

UK | Prevention and physical activity

The UK Chief Medical Officers' guidelines describe the benefits and recommended patterns of physical activity across the life course. The 2026 refresh reinforces that moving from inactivity to some activity produces important health gains, and that useful movement includes everyday routines as well as organised exercise.

For adults, the guidance retains the aim of at least 150 minutes of moderate-intensity activity each week, or an equivalent combination of activity, alongside muscle strengthening. Reducing prolonged sedentary time is also important. Older adults benefit from attention to strength and balance, while recommendations for children reflect their different developmental needs.

The guidance emphasises that activity should be sustainable and appropriate to the person. Walking, cycling, wheeling, dancing and other forms of movement can all contribute. Creating accessible opportunities and addressing barriers are therefore part of prevention. The message is not that everyone must follow the same exercise programme, but that more regular movement can support physical and mental health at different ages and levels of ability. Read document

S39 Protocol for Home Office registered forensic pathologists (2026)

England and Wales framework | Forensic pathology

The Home Office protocol sets expectations for forensic pathologists on its register in their work with the criminal justice system. It requires professional independence, appropriate competence and reliable service arrangements, including work within a recognised group practice.

A key assurance requirement is critical conclusions checking of forensic post-mortem examinations, together with participation in checking colleagues' work. Pathologists must manage workload so that quality and the integrity of the justice system are protected, and notify the relevant authority of circumstances that prevent an effective service.

The protocol also addresses compliance with professional standards, continuing development, appraisal and revalidation. Reporting, communication and arrangements for investigating concerns support accountability. Its central principle is that expert evidence must be dependable and independently reached: cooperation with police, coroners and other agencies does not remove the pathologist's responsibility to exercise impartial judgement and remain within their expertise. Read document

S40 Medicines optimisation (NICE NG5)

England-focused guidance | Medicines systems

NICE NG5 addresses the safe and effective use of medicines across health and social care. It emphasises reliable information, clear responsibility and patient involvement, particularly when people move between wards, organisations or care settings.

Medicines reconciliation should identify and resolve discrepancies between what a person is actually taking and what has been recorded or prescribed. Organisations need a defined process and trained, competent professionals responsible for carrying it out, involving patients and carers where appropriate.

Structured medication review considers whether each medicine remains appropriate, effective and safe, including the person's understanding, preferences, over-the-counter treatments and monitoring needs. The guideline also covers learning from medicines-related incidents and supporting self-management. Its overall focus is the outcome for the patient: preventing avoidable harm and treatment failure, reducing unnecessary medicines or waste, and ensuring that prescribing decisions remain connected to review and follow-up. Read document

S41 RCR Clinical Radiology Workforce Census (2025)

UK | Workforce report published in 2026

The Royal College of Radiologists' 2025 census describes a widening mismatch between demand for diagnostic imaging and the radiology workforce. Increasingly complex examinations require specialist interpretation, while shortages affect both routine reporting and the timely diagnosis on which other services depend.

The report highlights pronounced geographical inequalities. Smaller, rural and already under-resourced departments face particular difficulties recruiting enough radiologists and providing the necessary range of expertise. Reliance on outsourcing, additional paid reporting and locums provides short-term capacity but increases expenditure without resolving the underlying shortage. Future retirements add to the pressure.

Its central recommendation is sustained expansion of specialist training and workforce capacity, rather than repeated reliance on temporary solutions. Workforce planning needs to reflect the complexity of the work and the needs of underserved areas, not simply the number of scans performed. The census makes the connection between radiology staffing, diagnostic delays and the ability of the wider hospital to deliver timely care. Read document

S42 RCR Clinical Oncology Workforce Census (2025)

UK | Workforce report published in 2026

This Royal College of Radiologists census examines the clinical oncology workforce and its ability to provide radiotherapy and systemic anticancer treatment. It identifies shortages and uneven distribution of expertise as constraints on timely, high-quality cancer care.

Clinical leaders report treatment delays associated with insufficient staffing, including patients deteriorating while waiting. Smaller and rural cancer centres are particularly vulnerable: a limited number of consultants may need to cover several tumour types, making specialist cover and service resilience difficult. Recruitment restrictions compound these pressures rather than allowing services to match capacity to demand.

S42 RCR Clinical Oncology Workforce Census (2025)

UK | Workforce report published in 2026

The report calls for a planned increase in clinical oncology training and a more sustainable workforce. Its modelling considers the benefits of expanding training places over successive years rather than seeking a one-off recruitment solution. The main issue is not simply the national headcount: services also need the right distribution of specialists to provide timely treatment and dependable cover across cancer pathways. Read document

S43 NACEL: State of the Nations report (2026 publication)

England, Wales and Jersey | End-of-life care audit

The National Audit of Care at the End of Life examines the care of adults dying in hospitals in England, Wales and Jersey. Its 2026 report combines case-note review, bereaved people's feedback and information about service organisation.

The findings show substantial good practice: 84% of reviewed patients were recognised as likely to die, and most patients whose deaths were expected had an individualised care plan. Access to specialist palliative care was improving, but seven-day face-to-face provision remained incomplete. Most bereaved respondents rated care positively, although experience was not consistently good.

Important gaps concerned involvement and individual needs. Fewer than half of records documented patients' participation in decision-making, and spiritual, religious or cultural needs were recorded in only 49%. Missing ethnicity information and differences in outcomes also limited assurance about equitable care. The improvement priorities are earlier recognition, meaningful conversations, genuinely personalised care planning and more consistent access to specialist support, rather than treating completion of a care-plan form as sufficient. Read document

S44 End of life care for infants, children and young people (NICE NG61)

England-focused guidance | Children with life-limiting conditions

NICE NG61 describes how to plan and deliver end-of-life care for babies, children and young people with life-limiting conditions. It places the child and family at the centre of decisions, while recognising that communication, understanding and preferences change with age and circumstances.

A central recommendation is a jointly developed advance care plan. This should record the child's needs and wishes, the family's priorities, agreed treatment decisions, important contacts and arrangements for emergencies. It should be reviewed as circumstances change and shared between the professionals and services involved. An advance care plan is broader than a decision about resuscitation.

Care should combine symptom management with psychological, social, spiritual and practical support. Coordination between hospital, hospice and community teams is important so that families receive consistent advice and know whom to contact. Plans should address preferred places of care and death where feasible, support for parents and siblings, and bereavement needs. The overall aim is continuity and individualised care, not a standardised approach imposed on every family. Read document

S45 Service Standards for Sexual and Reproductive Healthcare (2022)

UK professional standards | Read current college updates alongside

These professional standards describe the organisation of safe, accessible sexual and reproductive healthcare. They cover leadership, service provision, patient focus and public involvement, rather than providing a prescribing guide for individual contraceptive methods.

Services should offer clear pathways to an appropriate range of care and explain where people can obtain provision that is not available locally. Information about access, choices and treatment should be understandable and available in formats and languages suited to the population, including people with sensory impairments. Consultations must allow enough time for informed choices and more complex needs.

The standards emphasise competent staff, clinical governance, confidentiality, privacy and dignity, with appropriate safeguarding arrangements. Young people's needs require particular attention, and chaperones should be offered for intimate examinations. Patient and public involvement should help shape services, including identifying barriers faced by people who find mainstream provision difficult to use. Access is therefore about the usability and acceptability of a service, not simply whether appointments exist. Read document

S46 Learning disabilities and behaviour that challenges (NICE NG11)

England-focused guidance | Children and adults

NICE NG11 addresses prevention, assessment and support when a person with a learning disability displays behaviour that challenges. It treats behaviour as something to understand in context, not as a diagnosis or an inevitable feature of the person's disability.

Assessment should explore what the behaviour communicates or achieves and consider physical illness, mental health, communication difficulties, sensory needs, relationships and the environment. The person should be involved through accessible communication, alongside appropriate involvement of family and carers. A shared understanding should lead to a written behaviour support plan with clear, practical actions.

The emphasis is on proactive, personalised support: adjusting environments and routines, developing communication and skills, and reducing triggers rather than relying on reactive responses. Staff and carers need training, supervision and support to implement the plan consistently. Interventions should be reviewed against their effect on behaviour, quality of life and any adverse consequences. The guidance therefore connects individual assessment with the way services themselves are organised. Read document

S47 Borderline personality disorder: recognition and management (NICE CG78)

England-focused guidance | Check NICE update status

NICE CG78 covers recognition, treatment and service organisation for borderline personality disorder. It emphasises respectful engagement and access to appropriate care; a diagnostic label should not be used to exclude someone from services or to dismiss their distress.

Management should be based on a coherent care plan, with agreed responsibilities, psychological treatment where appropriate and a clear approach to crises. Community services have a central role in continuity, supported by specialist assessment, advice and supervision. Changes of clinician, transfers and endings require careful planning because they can affect trust and engagement.

The guideline does not recommend medication specifically to treat borderline personality disorder or its individual symptoms, and advises against medium- or long-term antipsychotic treatment for the disorder itself. Treatment of coexisting conditions and carefully limited crisis prescribing are separate matters. Its central service message is consistent, coordinated therapeutic care rather than repeated crisis responses or escalating medication without a clear purpose. Read document

S48 RCPCH Progress+ curriculum and specialty syllabi

UK | Paediatric capabilities and subspecialty scope

RCPCH Progress+ is the UK postgraduate paediatric curriculum. It sets out the outcomes and capabilities expected across core and specialty training, with linked syllabi describing general paediatrics and individual subspecialties. It is a professional capability framework, not a report on the performance of paediatric services.

The curriculum spans eleven domains. Clinical assessment, management and procedures sit alongside communication, patient safety, quality improvement, leadership and teamwork. Safeguarding, education, research and professional development are also integral to the framework, reflecting the breadth of paediatric responsibility rather than technical knowledge alone.

Progression is based on demonstrating the relevant capabilities and outcomes. The subspecialty syllabi clarify the scope of advanced practice and its interfaces with other services, while the common domains retain expectations that apply to every paediatrician. The framework therefore brings together specialist expertise, safe multidisciplinary working and the ability to improve care and develop others. Service staffing and commissioning requirements must be obtained from the relevant service standards, not inferred from this curriculum. Read document

S49 Specialist immunology services for adults with deficient immune systems (2024)

England | Service specification

This NHS England specification sets requirements for specialist adult services for immune deficiency and immune dysregulation, excluding HIV. Its purpose is to reduce diagnostic delay, prevent avoidable complications and support long-term health and quality of life.

S49 Specialist immunology services for adults with deficient immune systems (2024)
England | Service specification

Care should be delivered by an appropriately skilled multidisciplinary team with access to specialist investigation, treatment and advice. Individual treatment may include immunoglobulin replacement and supported home therapy; patients needing advanced treatments should have access through appropriate referral arrangements. Outpatient, day-care, inpatient and emergency provision must connect into a coherent pathway rather than leave patients navigating separate services.

The specification also addresses continuity, including transition and transfer of care, patient education and ongoing monitoring. Quality assurance includes participation in relevant registries and accreditation through the Quality in Primary Immunodeficiency Services programme, or a clear plan towards it. These requirements link specialist clinical capability with dependable service organisation and evidence that outcomes and patient experience are being monitored. Read document

S50 Specialist allergy services: adult service specification (2025)
England | Service specification and related paediatric documents

The adult allergy service specification describes NHS England's expectations for specialist assessment and treatment of severe or complex allergic disease, including problems that have not been adequately managed through conventional services. Its aims include reducing avoidable morbidity and mortality and improving quality of life.

The service requires specialist multidisciplinary expertise, appropriate diagnostic facilities and access to treatments that cannot be delivered safely or effectively in less specialised settings. Assessment must connect the clinical history with suitable investigations, rather than relying on test results in isolation. Referral arrangements should link primary care, secondary care and specialist centres so that patients receive the right level of care.

Quality requirements concern safe provision, outcomes, accreditation and equitable access. The accompanying equality assessment recognises that the organisation of services can create barriers as well as clinical benefit. The adult specification should be distinguished from separate paediatric provision: age, transition arrangements and the population served are part of the service's defined responsibilities. Read document

S51 National Cardiac Audit Programme: second report 2025
UK programme | 2024/25 and 2022/25 data

NICOR's second National Cardiac Audit Programme report of 2025 brings together findings from eleven national cardiovascular audits. It considers patient safety, productivity and prevention, using data on different conditions and procedures rather than treating cardiac care as one uniform pathway.

Important concerns include delays in emergency heart attack treatment and transfers, continuing long waits for some cardiac surgery, and gaps in preventive treatment. The report identifies patients with heart failure and atrial fibrillation who were not receiving anticoagulation, illustrating how incomplete delivery of established treatment can leave avoidable risk.

There are also signs of improvement, including some reductions in surgical waiting times and greater use of admission on the day of surgery. However, shorter stays need to be considered alongside readmission and outcomes, not assumed to represent better care. The report supports more reliable treatment pathways, appropriate secondary prevention and rehabilitation, and investigation of variation in access and outcomes between centres and populations. Read document

S52 National Clinical Guideline for Stroke: organisation of services (2023)
UK and Ireland guideline | Stroke service organisation

The organisation-of-services chapter of the National Clinical Guideline for Stroke describes the whole stroke pathway, from urgent assessment to rehabilitation and longer-term support. It stresses that specialist organisation is itself a component of effective treatment.

Patients need rapid access to specialist assessment, brain imaging and appropriate reperfusion treatment, supported by organised stroke-unit care. Networks must make this expertise available reliably rather than depending on the hospital or time at which a patient presents. Multidisciplinary staffing and coordinated assessment are central to both acute treatment and rehabilitation.

S52 National Clinical Guideline for Stroke: organisation of services (2023)

UK and Ireland guideline | Stroke service organisation

Recovery requires more than discharge from the acute ward. Rehabilitation should address physical, communication, cognitive and psychological needs, with appropriate early supported discharge and continuing community input. Families and carers need information and involvement, and longer-term review should identify persisting or emerging difficulties. The guideline therefore links timely acute intervention with functional recovery, participation and continuity across hospital and community services. Read document

S53 National Diabetes Audit: quarterly report April 2025-March 2026

England quarterly release | Published July 2026

This National Diabetes Audit release reports care processes and treatment targets for April 2025 to March 2026. It provides data at general practice, primary care network and integrated care board level, helping identify whether essential elements of diabetes care are being delivered consistently.

The audit examines recorded monitoring and preventive care, alongside achievement of important treatment targets. Its purpose is to make gaps visible: people may receive some parts of routine diabetes care while missing others, and aggregate results can conceal variation between local services. The data support systematic follow-up and improvement rather than assuming that registration with a service guarantees complete care.

This is a quarterly, provisional release, not the final validated annual account. The reporting period changed from fifteen months to twelve months from 2024, so earlier results are not directly comparable without accounting for that change. Interpretation must distinguish genuine differences in care from differences in recording, completeness and measurement period. The release should not be presented as proof of a national improvement or deterioration that it does not establish. Read document

S54 Annual SHOT Report 2025

UK | Haemovigilance and transfusion safety

The Serious Hazards of Transfusion report uses UK haemovigilance reports to identify avoidable harm and weaknesses in transfusion systems. The 2025 report reinforces the need to meet transfusion safety standards and address gaps highlighted by the Infected Blood Inquiry.

A central finding is that errors remain strongly associated with communication failures, assumptions, distractions, staffing pressures, information technology and workplace culture. Safe transfusion therefore depends on reliable systems as well as individual technical competence. Workload, capacity and resilience during peaks of demand are part of the safety problem.

The recommendations include appropriate use of blood, consideration of alternatives and informed involvement of patients. Preventing transfusion-associated circulatory overload requires attention to risk and the patient's circumstances, while identification, sampling and administration processes must remain dependable. Incident learning should lead to stronger safeguards and assurance that they work, rather than repeated reminders to staff. The report connects clinical decisions, laboratory practice and organisational responsibility throughout the transfusion pathway. Read document

S55 National Neonatal Audit Programme: summary report on 2025 data

UK programme | Published October 2026

The National Neonatal Audit Programme's report on 2025 data examines care in England, Scotland, Wales and the Isle of Man. It reports improvement in several measures: mortality before discharge among babies born before 32 weeks fell below 6%, and more babies received their mother's milk at key stages of care.

Perinatal optimisation also improved, including deferred cord clamping, appropriate place of birth, admission temperature and antenatal magnesium sulphate. Nevertheless, substantial geographical variation remained in care and outcomes. Differences by ethnicity affected measures including early parental consultation, involvement in ward rounds, breastmilk feeding and deferred cord clamping.

The report recommends more consistent delivery of evidence-based perinatal interventions, stronger support for early breastmilk feeding and review of variation in mortality. Networks should work with units and families to understand and address inequalities through local improvement. Better data completeness, common standards and interoperability are also needed so that comparison supports learning rather than leaving important differences unexplained. Read document

S56 National Cancer Plan for England (2026)

England | National cancer strategy

England's 2026 National Cancer Plan sets an ambition for three in four people diagnosed with cancer to survive at least five years by 2035. It connects prevention, earlier diagnosis, timely treatment and improved experience, rather than focusing on treatment capacity alone.

The plan proposes stronger prevention and risk reduction, more effective detection and diagnostic pathways, and faster access to appropriate treatment. Innovation, research and clinical trials form part of improving outcomes, alongside the workforce, equipment and infrastructure needed to deliver care reliably. Reducing inequalities is important because access, risk and outcomes are not distributed evenly.

It also addresses living with and beyond cancer, recognising the need for personalised support and management of lasting effects. Delivery requires clear local leadership and accountability, with cancer alliances, providers and integrated care boards contributing to implementation and progress review. The ambition is a future goal, not a description of present survival or a guarantee that every proposed service change is already operational. Read document

S57 HFEA Code of Practice, ninth edition and current directions

UK | Licensed fertility services

The Human Fertilisation and Embryology Authority's Code of Practice explains the standards expected of licensed fertility clinics and embryo research centres. It brings together legal requirements, licence conditions, regulatory directions and guidance, so not every statement has the same legal status.

Key responsibilities include valid consent, clear information and access to counselling, protection of patient and donor information, and consideration of the welfare of any child who may be born. Storage, handling and identification of gametes and embryos require dependable systems because mistakes can have irreversible consequences.

Centres must maintain appropriate expertise, governance and records, report relevant incidents and meet the conditions of their licence. The ninth edition should be read with subsequent updates and current HFEA directions, rather than assumed to contain every later regulatory change. The overall focus is safe, ethical and accountable treatment, with informed choice and traceability throughout the patient's pathway. Read document

S58 Drug misuse and dependence: UK guidelines on clinical management (2017)

UK | The Orange Book; check linked updates

The UK guidelines on drug misuse and dependence, commonly called the Orange Book, describe comprehensive treatment for people experiencing drug-related problems. They combine harm reduction, treatment of dependence and support for recovery rather than treating prescribing as the whole intervention.

Assessment and care planning should consider substance use alongside physical and mental health, social circumstances and other needs. Psychosocial interventions and pharmacological treatment are complementary components of care. Services also need to address continuity across settings, including the criminal justice system, and adapt treatment for particular populations and circumstances.

The guidance emphasises engagement, coordinated treatment and interventions that help people build and sustain recovery. Effective provision therefore depends on the organisation of care and links with other services as well as the treatment selected. This remains a 2017 publication even when its hosting page is updated; subsequent guidance and safety advice need to be distinguished from the content of that edition. Read document

S59 Violence and aggression (NICE NG10)

England-focused guidance | Mental health, health and community settings

NICE NG10 addresses prevention and short-term management of violence and aggression across mental health, healthcare and community settings. It emphasises recognising triggers, understanding the person's needs and using skilled de-escalation before a situation reaches crisis.

Services should involve people in identifying their own warning signs and what helps them feel safe. Staff training, therapeutic relationships, clear care plans and the physical environment all contribute to prevention. Where a restrictive intervention is necessary to prevent harm, it must be proportionate, the least restrictive suitable option and used for no longer than required; it must never be punishment or a way of asserting dominance.

S59 Violence and aggression (NICE NG10)

England-focused guidance | Mental health, health and community settings

Following an incident, services should address physical and emotional harm, review what contributed and involve the person in learning. Organisations need programmes to reduce restrictive practice, with board oversight of incidents, experience and outcomes. The guidance therefore treats prevention and reduction of coercion as service responsibilities, not merely skills for staff responding to an emergency. Read document

D01 Standards for the dental team

UK | Dental professional standards

The General Dental Council's Standards for the dental team sets out professional duties across nine principles. These cover putting patients first, communication, consent, confidentiality, complaints, teamwork, maintaining skills, raising concerns and behaviour that sustains confidence in the profession.

The standards require care to be based on patients' interests and informed choices. Consent is an ongoing discussion about options and relevant information, not simply a signature. Patients should receive understandable explanations, have their information protected and be able to raise complaints through an effective process.

Dental professionals must work within their competence, keep knowledge and skills up to date and cooperate with colleagues. They must act when patients may be at risk rather than assuming that responsibility belongs to someone else. The framework applies to the whole dental team: professional conduct, reliable communication and clear responsibility are as important as technical treatment. These are regulatory expectations, not optional aspirations or findings from a service audit. Read document

D02 Delivering Better Oral Health: prevention toolkit

England publication | Evidence-based dental prevention

Delivering Better Oral Health brings together evidence-based advice for preventing dental disease and improving wider health. Its principal topics are dental caries, periodontal disease, oral cancer and tooth wear, supported by practical summary tables and the evidence behind the recommendations.

The toolkit covers fluoride, oral hygiene and dietary advice alongside tobacco cessation and lower-risk alcohol consumption. Preventive measures should be matched to age, need and risk rather than delivered as identical advice to every patient. The guidance connects oral disease with shared risk factors for other health conditions, making prevention relevant beyond the dental surgery.

Behaviour change is a specific part of the toolkit: giving information is not the same as helping someone make a feasible change. Dental teams should use clear advice and practical support suited to the individual's circumstances. The fourth edition was published in 2021, with case studies and presentational updates added in 2025; those updates should not be mistaken for an entirely new set of preventive recommendations. Read document

D03 Guidance to the Ionising Radiation (Medical Exposure) Regulations

Great Britain framework | Check separate Northern Ireland requirements

This guidance explains the Ionising Radiation (Medical Exposure) Regulations 2017 and the 2024 amendments in Great Britain. It covers medical exposure for diagnosis, treatment and research, with separate responsibilities for the employer, referrer, practitioner and operator. Northern Ireland has its own regulatory arrangements.

Two central principles are justification and optimisation. An exposure must have sufficient expected benefit to justify its risk, and the way it is delivered must keep exposure appropriate to the intended clinical purpose. These responsibilities are supported by properly trained and entitled staff, written procedures, accurate patient identification and suitable information for patients.

Employers also need quality assurance, appropriate equipment arrangements, clinical audit and systems for recognising and investigating accidental or unintended exposures. Relevant events must be reported through the required routes. The guidance is therefore about the complete system that makes an examination or treatment safe, not simply using the lowest possible radiation dose irrespective of diagnostic or therapeutic value. Read document

22.7 Newer service frameworks: what to add to your reading

A framework can bring several specialties together around a common service problem. Select it when the population, pathway or responsibility in your prospective post is within its scope. Do not assume that every document published by NHS England applies across the UK or to the Republic of Ireland.

The cardiovascular disease modern service framework is not the cardiothoracic surgery GIRFT report. The former concerns the wider cardiovascular, kidney and metabolic pathway; the latter remains useful for the organisation and quality of surgical services. For a cardiothoracic appointment, read the relevant parts of both rather than treating their titles as interchangeable.

Document	Most relevant when preparing for	How to use it
F01 Cardiovascular disease modern service framework	Cardiology, cardiothoracic surgery, stroke, renal medicine, diabetes and related pathways.	Add the pathway perspective to the existing specialty audit and service documents.
F02 Sepsis modern service framework	Acute, emergency, intensive care, infectious diseases, microbiology and other services managing severe infection.	Understand reliable recognition, treatment, recovery and coordination across settings.
F03 Mental health personalised care framework: modern care programme approach	Adult and older people's services for severe mental-health problems.	Explain clear responsibility, meaningful care planning, review and routes back to help.
F04 Best practice guide for NHS frailty pathways	Geriatrics, general and acute medicine, emergency and perioperative services.	Apply assessment, patient goals and hospital-community coordination to the local pathway.

Publication status matters. At the November 2026 check, the frailty and dementia modern service framework was still forthcoming; the May 2026 frailty pathway guide was already available. Do not claim to have read an unpublished framework. Check the official page again shortly before interview, and distinguish an announcement or consultation from implemented policy.

Four selected document briefs

F01 Cardiovascular disease modern service framework
England | July 2026; accessible version updated October 2026

This 2026 framework sets England's ten-year ambition to reduce premature deaths from heart disease and stroke by 25%. It takes a combined cardiovascular, kidney and metabolic approach because hypertension, diabetes, kidney disease, obesity and other risks frequently coexist and are too often managed separately.

The immediate priorities are to identify people with undiagnosed or inadequately managed risk, optimise established treatments and improve adherence. Prevention is intended to be proactive and increasingly delivered through neighbourhood services, supported by population data rather than waiting for patients to develop complications. Timely treatment for heart attack and stroke, and better access to rehabilitation, remain essential parts of the pathway.

Reducing inequalities runs throughout the framework. It calls for greater support where need is greatest, consistent delivery of effective interventions and measurement of access and outcomes. The twelve priorities have associated metrics and ambitions. This is a cross-specialty service framework, not a cardiothoracic surgical training or technical competency framework. Read document

F02 Sepsis modern service framework
England | July 2026; updated September 2026

The Sepsis Modern Service Framework sets an ambition to reduce deaths, life-threatening complications and the long-term effects of sepsis and severe infection by at least 25% by 2035. It covers the whole pathway, including prevention, recognition, diagnosis, escalation, treatment and recovery.

F02 Sepsis modern service framework

England | July 2026; updated September 2026

The framework seeks more consistent care across settings and patient groups. Priorities include better public and professional awareness, support for people at higher risk, earlier recognition of deterioration and timely access to appropriate treatment. Community and primary care services are part of this response, rather than sepsis being treated solely as an emergency department or intensive care issue.

It also proposes improved diagnostics, better use of data, research and coordinated improvement programmes. Work on faster pathogen identification and antimicrobial resistance should support more accurate treatment, while follow-up needs to recognise lasting effects after the acute illness. The framework sets a service-development direction; it does not replace clinical assessment, current treatment guidance or local escalation arrangements. Read document

F03 Mental health personalised care framework: modern care programme approach

England | Published 2026

This framework describes personalised care for adults and older people with severe mental health problems. It revisits the principles of the Care Programme Approach while addressing inconsistent access, limited co-production and insufficient attention to outcomes.

Everyone should have a current care and support plan based on a meaningful assessment of needs, strengths and goals. Planning should be undertaken with the person, not completed as an administrative exercise on their behalf. A named worker and clear multidisciplinary responsibilities support continuity, particularly where several agencies are involved. The plan should change when circumstances or needs change.

Services should measure and respond to both treatment outcomes and the person's experience, maintain routes back to support and avoid unnecessary repetition of assessments. Safety assessment and planning form part of the overall approach, considering risks to the person and others alongside contextual and treatment-related harm. The central aim is coordinated, responsive care with clear responsibility, rather than classification into a care-management category without reliable follow-through. Read document

F04 Best practice guide for NHS frailty pathways

England | May 2026

This best-practice guide sets out how NHS frailty pathways should provide coordinated, personalised care that people and carers can navigate. It links prevention and proactive community support with urgent care, hospital treatment and follow-up, rather than treating each episode as a separate problem.

The guide emphasises identifying frailty and undertaking appropriate holistic assessment, including comprehensive geriatric assessment. Care planning should reflect the person's goals and clinical needs, with advance planning where appropriate. Acute services need to recognise frailty early and maintain continuity with the professionals supporting the person at home.

Neighbourhood-level plans should be jointly owned by the NHS and local government, with resources and specialist input supporting community delivery. Shared information and outcome measurement are important to make coordination work in practice. The intended benefit is care that preserves wellbeing and independence while responding reliably to deterioration. This published guide is distinct from the separately proposed frailty and dementia modern service framework. Read document

23

Preparing across healthcare systems



Wales, Scotland, Northern Ireland and the Republic of Ireland: understand the local system, select the right reading and translate your experience into a relevant contribution.

Use this chapter for the country of your prospective post. It adds local context to the interview techniques and specialty reading already covered; it is not a requirement to learn five health systems.

23.1 Prepare for the system in which you will work

The interview techniques in this handbook travel well. Clear evidence, judgement, leadership, compassionate care and the ability to improve a service matter across countries. The names of organisations, professional requirements, appointment arrangements, legislation and national priorities do not transfer automatically. An answer can be clinically sensible but poorly tailored if it describes the wrong system.

Use the country section relevant to the post, alongside the specialty directory in Chapter 22 and the employer's own information. You do not need to learn five health systems. Select one national strategy, one current delivery document, one relevant safety or quality framework and the most useful specialty source. Where these overlap, read selectively rather than adding another document simply to complete a list.

England is not a synonym for the NHS

The 10 Year Health Plan for England, English integrated care boards, CQC arrangements and PSIRF should not be presented as the local system in Wales, Scotland or Northern Ireland. Useful lessons may transfer, but local structures and requirements must be checked. The Republic of Ireland is a separate jurisdiction and its public health service should not be called the NHS.

Similarly, do not assume that an English AAC model, a particular consultant contract or the panel's scoring process applies everywhere. Check the vacancy information for the employer, eligibility, professional registration, selection criteria, interview format, presentation instructions and any ranking or panel arrangements. For an Irish post, check the Medical Council and the recruiting organisation's requirements rather than assuming that UK registration or experience automatically meets them.

Four questions before you rehearse a local-policy answer

Who is responsible for this service? What national and local priorities matter to it? Which quality, safety and professional processes apply? What could I realistically contribute in this particular role? These questions are more useful than memorising an organisational chart without understanding the patient pathway.

INTERVIEW INSIGHT

Translate the principle, not just the terminology

"I would use PSIRF" is not a portable answer to every incident scenario. The portable elements are immediate safety, openness, appropriate reporting, support for those affected, proportionate learning and effective improvement. Name the local framework only when you know it applies. The same care is needed with consent, capacity, mental health, equality, safeguarding and data-protection requirements.

23.2 Wales: integrated care, quality and language

NHS Wales is organised around local health boards, NHS trusts and supporting national organisations. Health boards have responsibilities across primary, community and hospital services. Research the actual employing organisation and the pathway around it; do not substitute an English commissioner-provider description or assume that every consultant works for an NHS trust.

A Healthier Wales provides the long-term direction, with refreshed actions and subsequent delivery priorities. The NHS Wales Planning Framework 2026-2029 provides a more immediate planning context. The useful interview connection is between a strategic ambition and a workable local service: who needs care, where it can safely be delivered, what capability is needed and how the benefit will be measured.

Four themes to understand

Joined-up care: consider the links between hospital services, primary care, community teams and social care. Earlier intervention is not simply sending work out of hospital; the receiving service must have capacity, information and a clear route back to specialist advice.

Quality and value: explain how a proposal would improve outcomes that matter to patients, reduce avoidable variation and make responsible use of resources. The Welsh duty of quality and associated quality standards give this an explicit organisational context. Value is not the cheapest intervention irrespective of outcome.

Access and delivery: understand the board's own priorities for planned care, diagnostics, urgent care and workforce. Read the relevant annual expectations rather than importing English targets. Be able to identify one bottleneck and one realistic improvement to investigate with colleagues.

Language and inclusion: More than just words emphasises the Active Offer of Welsh-language care, rather than placing the burden entirely on the patient to ask. Consider language needs when planning communication, assessment, staffing and patient information. Do not imply that being bilingual is mandatory for every post; check the person specification and local requirements.

Governance and interview application

Wales has its own organisational duties of quality and candour, and Healthcare Inspectorate Wales has a distinct role. Llais represents people's interests across health and social care. Learn the employer's incident, complaints, patient-involvement and speaking-up arrangements instead of replacing their names with English equivalents.

A useful interview example might concern improving a follow-up pathway. Explain how you would agree the pathway with primary and community colleagues, identify people whose language or access needs are not being met, test a safe alternative and measure outcomes as well as activity. The purpose is to show that you understand how the service fits its population.

PRACTICE QUESTION

Applying Welsh priorities to your specialty

"How would you improve access while protecting quality?" Prepare an answer covering the local bottleneck, the partners needed and how you would test the change. Include Welsh-language needs where relevant, but avoid claiming that a national policy has already been fully implemented in the department.

23.3 Scotland: person-led care, value and service renewal

For a Scottish post, understand the employing NHS board and its relationships with primary care, community services and local integration arrangements. Healthcare Improvement Scotland, Public Health Scotland and the relevant local governance structures have distinct functions. An English trust and ICB model is not an interchangeable description.

The Health and Social Care Service Renewal Framework describes a ten-year direction built around prevention, people, community, population planning and digital capability. Realistic Medicine provides a complementary clinical perspective: decisions should reflect what matters to the person, with attention to benefit, harm, uncertainty and responsible use of resources.

Four themes to understand

Person-led decisions: be able to explain how you discuss options and uncertainty with patients, rather than equating technically possible treatment with the treatment every person would choose. For a consultant, this also includes helping the team recognise low-value or burdensome care.

Community and pathway working: consider how specialist advice, diagnostics, rehabilitation and support can be coordinated around a person. Hospital at Home or other community models need appropriate selection, workforce, escalation and reliable information; the setting alone does not prove better care.

Geography and equity: travel, rurality, island services and deprivation may affect access, recruitment and continuity. Ask how the specific department manages these pressures. A digital option can help some patients while excluding others, so retain a clinically appropriate alternative and assess who benefits.

Learning and improvement: use the Scottish adverse-event framework and local processes when discussing incident learning. Do not assume PSIRF is the national Scottish framework. Understand the separate organisational duty-of-candour arrangements and follow the relevant local guidance.

Distinguish planned reform from current arrangements

The Scottish Government's October 2026 staff information describes plans to move from 14 territorial boards to two and states that the work is in the design phase. Do not describe the proposed structure as already operational. Check the current employer and the latest implementation information before interview. A credible answer distinguishes the intended benefits from the practical questions of transition, workforce, local accountability and continuity of care.

This is an opportunity to demonstrate balanced judgement rather than political allegiance. You can support collaboration and reduced duplication while asking how change will preserve local knowledge, staff engagement and access for remote communities. Discuss the clinical contribution you could make without claiming authority over the national reorganisation.

PRACTICE QUESTION

More treatment is not always better care

"How does Realistic Medicine affect your work?" Use a genuine example of understanding the patient's priorities, explaining alternatives and agreeing a proportionate plan. Then describe how you would support consistent shared decision-making within the team. Do not present it merely as a cost-reduction policy.

23.4 Northern Ireland: Health and Social Care, networks and openness

Use Health and Social Care, or HSC, when discussing Northern Ireland's public system. HSC trusts provide health and social care services, but organisational integration does not mean every interface works smoothly. Understand how the employing trust works with primary care, community partners and regional planning. RQIA, the Public Health Agency and the Department of Health have different roles; they are not alternative names for a single organisation.

The three-year strategic plan was published in December 2024 around stabilisation, reform and delivery. The hospital-network work, neighbourhood model and Being Open Framework provide further context. Check what is being implemented in the employing service rather than treating every national proposal as a completed local change.

Four themes to understand

Access and capacity: discuss the consequences of waiting, prioritisation, cancellations, diagnostics and workforce constraints in your specialty. An answer about waiting lists should include safety, equity and the reliability of the pathway, not simply an intention to work faster.

Networks and service configuration: consider which care can be delivered locally and which may benefit from a networked specialist service. Quality, workforce sustainability, travel, transfers and continuity all matter. The hospital-network consultation response was published in September 2026; specific reconfiguration proposals still require attention to their own status and process.

Care closer to home: the neighbourhood model brings local providers together around prevention and coordinated care. A consultant can contribute through specialist advice, shared pathways and reliable discharge arrangements, while checking that risk and workload are not merely transferred to an unsupported community service.

Openness and trust: the Being Open Framework was published in February 2026. Use it to discuss listening, honest communication, fair learning and the response to concerns. Do not describe a framework as if it were automatically identical to the statutory candour arrangements elsewhere; check the local requirements for the situation.

Apply the priorities to a realistic service problem

For a proposed network pathway, identify the patients who would benefit, the expertise and cover required, and the arrangements for access, deterioration and follow-up. In border-area or regional services, establish the actual referral and information-sharing arrangements rather than assuming that geographical proximity creates an agreed pathway.

In an interview, a thoughtful limitation is often valuable: "I would first establish whether the community capacity and specialist support are in place, rather than assuming that earlier discharge alone is an improvement." This shows responsibility for the whole pathway without implying that a new consultant can personally solve every capacity problem.

PRACTICE QUESTION

Integrated on paper, fragmented in practice

"Why can discharge still be difficult in an integrated health and social care system?" Consider capacity, information, decision-making, housing, transport and differing professional assessments. Explain how you would clarify ownership and work jointly, rather than blaming another part of the system.

23.5 Republic of Ireland: Slaintecare, HSE regions and local accountability

The Republic of Ireland has its own health system, professional regulation and legal framework. The HSE remains a single organisation with six health regions bringing hospital and community care together. Establish the employing body's identity, the relevant region and integrated health area, and the responsibilities attached to the advertised post. Not every hospital has identical governance or employment arrangements.

Slaintecare sets the reform direction towards accessible, affordable, high-quality care. Slaintecare 2025+ provides a roadmap for 2025-2027, with subsequent annual actions. The HSE National Service Plan 2026 translates wider priorities into service delivery. For interview preparation, concentrate on the implications for your prospective patients and service rather than memorising a budget or a list of national projects.

Four themes to understand

Access and fairness: consider waiting times, the relationship between capacity and demand, and whether some groups face greater barriers. Avoid assuming that service entitlements, charges or public-private arrangements are the same as in the UK. Check the pathway that applies to the post.

Regional integration: explain how your service would work with primary, community and social care, including communication, named responsibilities and access to specialist input. The formation of health regions is an organisational change; better patient experience still depends on how people work together.

Quality and openness: HIQA's National Standards for Safer Better Healthcare provide a service-quality framework within their scope; mental health has distinct regulatory arrangements through the Mental Health Commission. The HSE Open Disclosure Policy 2025 is particularly useful for discussing communication after patient-safety incidents. Do not substitute CQC terminology or PSIRF for the applicable Irish processes.

Professional contribution: learn the organisation's values and the published selection criteria. Support claims about clinical judgement, leadership, service delivery, teaching and research with your own evidence. Check Medical Council registration requirements, the recruitment pack and the relevant consultant contract rather than assuming automatic equivalence with a UK post.

Prepare for local interviews, not a translated NHS script

A motivation answer should explain why this organisation and role are right for your contribution. Referring only to the HSE as if it were one undifferentiated employer does not demonstrate knowledge of the department. Find out about its population, clinical networks, academic relationships, workforce and planned developments.

For a service-development answer, connect a national priority with one local proposal and an achievable first step. For example, explore where a pathway could improve coordination between hospital and community care, who would need to agree the change, and how you would measure access, experience and outcomes. Keep the clinical detail appropriate to a mixed panel.

PRACTICE QUESTION

Making reform relevant to the job

"What does Slaintecare mean for this post?" Explain the relevant principle, identify a specific interface in the advertised service and describe your contribution. Avoid saying only that care should move into the community: explain the capability, communication and safeguards that would make that change work.

23.6 A small reading plan for your country and specialty

Use the four summaries for the relevant country as a selection guide, not a requirement to read every page. Start with the national direction, the recommendations that relate to the role and relevant local implementation information. The summaries explain the main issues and recommendations; they do not replace professional guidance or the complete document where detail is necessary.

For every country, add the employer's strategy or service plan, relevant inspection or assurance information, and recent local performance or quality data. Then choose one or two specialty documents from Chapter 22, checking their geographical scope. A UK-wide professional standard, an England-only service specification and an Irish national clinical guideline are not interchangeable.

Before interview, verify publication dates and implementation status. A consultation, an announced framework and an operational requirement are different. Where a major reform is still being designed, explain the direction and the questions it raises without inventing detail. No candidate needs to predict the outcome of a policy process.

23.7 Country reading directory

Start with the national direction and one delivery or governance document that is especially relevant to the role. Then add a specialty source and the employer's own priorities. The four entries per country below are a choice of useful starting points, not four compulsory reports to memorise.

Country	Direction and delivery	Quality, experience and practice
Wales	WAL01 A Healthier Wales WAL02 Planning Framework 2026-2029	WAL03 Duty of Quality WAL04 More than just words
Scotland	SCO01 Service Renewal Framework SCO02 Reform: staff information	SCO03 Our Path Ahead SCO04 Adverse-event learning framework
Northern Ireland	NIR01 HSC Three Year Plan NIR02 Hospital network consultation and response	NIR03 Being Open Framework NIR04 Neighbourhood Model
Republic of Ireland	IRL01 Slaintecare 2025+ IRL02 HSE Service Plan 2026	IRL03 Safer Better Healthcare standards IRL04 Open Disclosure Policy 2025

Each entry summarises the document's purpose, main priorities or findings, and recommendations. Dates identify the document or edition, not proof that every proposed change has been implemented. Official links are retained for targeted reading.

Wales: four selected documents

WAL01 A Healthier Wales: long-term plan and refreshed actions
Wales | 2018 plan; refreshed actions 2024

A Healthier Wales sets the long-term direction for an integrated health and social care system that helps people remain healthy and independent. Its emphasis is on prevention, earlier intervention and care closer to home, with services organised around people rather than institutional boundaries.

The refreshed 2024 actions develop this direction through integrated community care, rehabilitation, reablement and recovery. They also address timely access, women's and children's health, equitable outcomes and communication in the language or format people need. Value-based healthcare means using resources to achieve outcomes that matter, while reducing unnecessary variation and harm.

WAL01 A Healthier Wales: long-term plan and refreshed actions

Wales | 2018 plan; refreshed actions 2024

Implementation depends on workforce development, compassionate leadership, digital records and reliable information sharing, research and partnership with citizens and carers. Digital expansion should not exclude people who cannot use it. The plan provides strategic direction; subsequent delivery and planning documents set more specific expectations. Its central proposal is a coordinated, preventive system, not simply transferring existing hospital activity into a different building. Read document

WAL02 NHS Wales Planning Framework 2026-2029

Wales | Published March 2026; updated August 2026

The NHS Wales Planning Framework 2026-2029 directs health organisations to connect three-year priorities with annual delivery expectations and financially balanced plans. It requires progress on current pressures alongside longer-term service transformation.

Its six strategic priorities are timely access to care, population health and prevention, community by design, mental health access, women's health, and quality and safety. Timely access includes reducing waits for diagnostics and treatment and improving urgent pathways; the accompanying annexes set out detailed expectations and enabling actions for the planning period.

The framework stresses productivity, efficiency and reducing waste, harm and variation within a difficult financial settlement. Organisations must therefore show how priorities will be delivered with the workforce, capacity and resources available, not merely reproduce national ambitions. Community provision and prevention are part of that response, alongside improving hospital performance. The document describes required plans and intended delivery; it is not evidence that every organisation has already achieved the standards. Read document

WAL03 Duty of Quality statutory guidance and quality standards

Wales | 2023

The Welsh Duty of Quality requires Welsh Ministers and NHS bodies to exercise their health functions with a view to improving the quality of health services. It applies across decision-making and planning, including non-clinical functions, rather than being confined to clinical audit or incident management.

The accompanying standards define six dimensions of quality: safe, timely, effective, efficient, equitable and person-centred care. Decisions should be informed by population needs, evidence and the involvement of people affected. The guidance links quality with prudent and value-based healthcare, including avoiding unnecessary variation and focusing on outcomes and patient goals rather than cost alone.

Leadership, workforce, culture, information, learning and improvement, and a whole-system approach are the enabling conditions. NHS bodies must build these into governance and quality management and account publicly for progress. The duty therefore makes quality a continuing organisational responsibility, not an occasional improvement project. It is distinct from the separate duty of candour when things go wrong. Read document

WAL04 More than just words: Welsh-language plan 2022-2027

Wales | 2022-2027 plan

More than just words is Wales's 2022-2027 plan to embed Welsh-language provision in health and social care. Its core principle is the Active Offer: services should proactively offer care in Welsh rather than require patients or families to request it.

Language is treated as part of safe, person-centred care, not merely a matter of preference. It can affect understanding, trust and assessment, particularly for children, older people, people with dementia or learning disabilities, and those using mental health services. The plan responds to inconsistent availability and quality of Welsh-language provision.

Recommendations focus on leadership and accountability, recognising and developing workforce language skills, and building bilingual provision into planning, commissioning, training and digital systems. Patient information and records should help services identify and respond to language needs. The intended change is an organisational capability that works consistently across a pathway, rather than depending on a helpful Welsh-speaking individual being available by chance. Read document

Scotland: four selected documents

SCO01 Health and Social Care Service Renewal Framework

Scotland | June 2025

Scotland's 2025 Service Renewal Framework sets a ten-year direction for sustainable, accessible health and social care. It builds on operational improvement and population-health work, recognising increasing demand and financial pressures.

Five principles guide renewal: prevention throughout care; services designed around people; more care in communities; planning around population need rather than organisational boundaries; and effective use of digital technology. Proposed changes include earlier detection and management of long-term conditions, expanded community access, better integration and redesign of hospital services as more appropriate care becomes available elsewhere.

The framework supports shared decision-making, better access to personal health information and more collaborative working across organisations. Resources should increasingly support primary and community care, while national consistency reduces duplication and unwarranted variation. NHS boards and integration authorities remain accountable for planning and delivery, with staff and public involvement. It is a strategic framework for change, not a claim that the proposed service model has already been achieved. Read document

SCO02 Health and care reform: staff information

Scotland | 22 October 2026; proposals in design

Published in October 2026, this staff briefing explains proposals to replace Scotland's fourteen territorial NHS boards with two, covering the east and west. The stated aims are simpler planning, less duplication, more consistent access and stronger collaboration across services.

The publication explicitly places the programme in its design phase, with a business case and detailed transition arrangements still to be developed. Existing integration arrangements remain in place while their future is considered. Routine and community care are intended to remain local where possible, with specialist services organised to support quality and workforce sustainability. Rural and island needs require specific attention.

The briefing commits to workforce engagement and partnership working, protection of existing employment terms and careful management of change. It distinguishes organisational restructuring from the service redesign needed to improve outcomes. These are proposed reforms and assurances about their intended operation, not evidence that the two-board model or any particular service relocation is already in place. Read document

SCO03 Our Path Ahead: Chief Medical Officer annual report 2025-2026

Scotland | June 2026

The Chief Medical Officer's 2025-2026 report considers how Scotland can provide careful, kind and sustainable care amid greater complexity, technological change and constrained resources. It builds on Realistic Medicine and focuses on outcomes that matter to people.

Shared decision-making, personalised care and honest discussion of uncertainty remain central. The report argues for resource stewardship: avoiding waste and unwarranted variation while directing effort towards meaningful benefit. Innovation and digital tools should support relationships and better decisions, not displace the human element of care or weaken trust.

It also emphasises the wider conditions that create health, including the circumstances in which people live, and the need to address inequalities. Trust depends on listening, transparency, confidentiality and fair use of resources. The report is a professional and system-level direction rather than a technical protocol: its message is to redesign services around people while evaluating change carefully and retaining compassion under pressure. Read document

SCO04 Reviewing and learning from adverse events in NHS Scotland

Scotland | National framework, February 2025

Healthcare Improvement Scotland's February 2025 framework sets a national approach to reviewing and learning from adverse events. It aims to make reviews more consistent and to place patients and families at the heart of the process, rather than treating their involvement as a final communication exercise.

SCO04 Reviewing and learning from adverse events in NHS Scotland
Scotland | National framework, February 2025

The approach connects reporting, appropriate review and improvement. Reviews need to understand the context in which care was delivered and the factors contributing to harm, with suitable expertise and support for those affected. NHS boards implement the framework through their local reporting and governance arrangements; national expectations do not remove local responsibility for the quality of each review.

Learning must lead to actions that are followed through and shared, including across organisations where the same risks may recur. Completing a report is therefore not the endpoint: services need evidence that improvements have been implemented and have addressed the problem. This is Scotland's framework and should not be described as England's Patient Safety Incident Response Framework. Read document

Northern Ireland: four selected documents

NIR01 Health and Social Care NI: Three Year Plan
Northern Ireland | Published December 2024

Northern Ireland's December 2024 three-year plan is organised around stabilisation, reform and delivery. It recognises that immediate financial, workforce and demand pressures must be managed while the system changes to meet future needs.

Stabilisation concerns sustaining essential services and limiting deterioration. Reform includes stronger primary, community, social care and mental health provision, alongside hospitals working as an interdependent network. Delivery means safe, sustainable care as close to people as appropriate, with action on long waits, cancer services and health inequalities.

Workforce development, digital capability, collaboration and sustainable funding are central enablers. The plan also links health outcomes to wider factors such as housing, education and employment, so prevention cannot be delivered by hospitals alone. Progress is intended to be monitored through strategic outcomes and shorter-term oversight measures. The plan is a direction and set of commitments, not an assurance that the service pressures it describes have been resolved. Read document

NIR02 Hospitals: Creating a Network for Better Outcomes
Northern Ireland | Consultation framework; response September 2026

Hospitals: Creating a Network for Better Outcomes sets out Northern Ireland's case for hospitals operating as an integrated network rather than isolated institutions. The aim is to organise expertise and capacity so that services are safe, sustainable and capable of delivering better outcomes.

Its principle is local provision where possible and centralised specialist care where necessary. It considers the roles of different hospitals, access pathways, travel and transport, and the sequence of future service reviews. Reconfiguration must also connect with primary, community, social care and mental health provision; hospital redesign alone cannot resolve wider system pressures.

The consultation and subsequent analysis address both the potential benefits and public concerns about access and change. They provide strategic context for individual service decisions rather than approving every possible local reconfiguration. The key issues are clinical quality, workforce sustainability, reliable transfers and fair access, with evidence and engagement needed as detailed proposals are developed. Read document

NIR03 Being Open Framework for Health and Social Care
Northern Ireland | February 2026

Northern Ireland's Being Open Framework, published in February 2026, establishes a regional approach to openness, honesty and transparency across Health and Social Care. It applies to everyday relationships as well as communication when care has gone wrong.

Patients, families and carers should be listened to and treated fairly and compassionately. Staff need visible, inclusive leadership and a psychologically safe environment in which concerns can be raised and acted on. Openness therefore depends on organisational support and leadership behaviour, not simply an instruction to individuals to speak up.

NIR03 Being Open Framework for Health and Social Care
Northern Ireland | February 2026

The framework brings together a just, learning culture with accountability. It expects organisations to support staff, learn from experience and strengthen trust through honest communication and follow-through. The aim is better safety and public confidence, while avoiding defensiveness or blame that suppresses information. It should be distinguished from specific statutory duties: publication of a cultural framework does not itself establish the same legal arrangements as another jurisdiction. Read document

NIR04 Neighbourhood Model of Health and Wellbeing: official guide
Northern Ireland | Phased implementation from April 2026

The Neighbourhood Model of Health and Wellbeing aims to bring Northern Ireland's services together around local population needs. Prevention, earlier support and care closer to home are intended to improve outcomes and reduce avoidable use of ambulances and hospitals.

The model provides for seventeen integrated neighbourhood teams aligned with GP federation areas. These bring together general practice, community pharmacy, nursing, allied health professionals, social care, councils and voluntary and community organisations. The emphasis is shared planning and coordination around communities, recognising that different places have different needs and resources.

Implementation is phased, beginning from April 2026 after design and development work. Establishing teams is accompanied by investment, evaluation, measurement of outcomes and scaling of useful practice. The intended benefit is earlier, more joined-up support rather than simply adding another referral layer. Specialist services remain part of the wider system, with local working arrangements needing to support appropriate escalation and continuity. Read document

Republic of Ireland: four selected documents

IRL01 Path to Universal Healthcare: Slaintecare 2025+
Republic of Ireland | Roadmap 2025-2027

Slaintecare 2025+ sets Ireland's 2025-2027 roadmap towards accessible, affordable, high-quality healthcare. Its three priority areas are better access, improved service quality and increased capacity, supported by twenty-three projects and implementation milestones.

The programme seeks shorter waits and fairer access through expanded and better-integrated community care, greater service capacity and workforce reform. Prevention and healthy living are included alongside treatment. Modern digital infrastructure, innovation and productivity improvements are intended to support a more responsive system rather than simply increase activity within existing arrangements.

The HSE health regions are an important enabling reform, intended to align planning and delivery more closely with population needs. The roadmap is a live programme, with further annual actions and some reforms extending beyond 2027. Universal healthcare is the direction of travel: the publication should not be read as evidence that all financial, access or capacity barriers have already been removed. Read document

IRL02 HSE National Service Plan 2026
Republic of Ireland | 2026 service plan

The HSE National Service Plan 2026 translates strategic commitments into annual service delivery, resources, activity and performance expectations. It follows five corporate pillars: healthy communities, the right care, the right place, the right time and strong foundations.

Priorities include better access across hospital, community, mental health and disability services; additional beds and surgical capacity; and more integrated care near home. The plan emphasises reducing the time people wait, making effective use of available facilities and improving productivity through workforce organisation, digital services and different ways of working.

Six health regions have greater scope to plan around their populations, alongside national services and common standards. Increased autonomy is paired with clearer accountability, comparative performance information and improvement requirements where services fall behind peers. The document is a delivery plan with targets and commitments, not a retrospective account of achieved results. Its central challenge is turning available resources into more consistent access, experience and outcomes. Read document

IRL03 National Standards for Safer Better Healthcare

Republic of Ireland | Version 2, September 2024; update under review

HIQA's National Standards for Safer Better Healthcare describes the outcomes and organisational arrangements expected of high-quality services. The standards apply to relevant HSE-provided or funded healthcare and private hospitals, with mental health services covered by separate arrangements.

Eight connected themes combine person-centred care, effective care, safety and better health and wellbeing with leadership and governance, workforce, use of resources and use of information. Patients' rights, dignity, preferences and participation are integral: communication, consent and accessible complaints processes are part of quality, not additions to technical care.

The standards provide a framework for identifying strengths and gaps and for demonstrating reliable improvement. Clear accountability, competent staff and usable information enable good care to be delivered consistently. The 2024 version reflects the extension of HIQA's remit to private hospitals. A later review of the standards does not itself replace the published requirements; proposed changes and approved standards must be distinguished. Read document

IRL04 HSE Open Disclosure Policy 2025

Republic of Ireland | Replaces the 2019 policy

The HSE Open Disclosure Policy 2025 sets requirements for communicating with patients and relevant persons after patient safety or notifiable incidents. It applies across HSE and HSE-funded services and supports implementation of Ireland's national framework and the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

The policy emphasises open, honest, timely and compassionate communication to avoid compounding the harm already experienced. It describes the stages of disclosure, responsibilities, governance and support for patients, families and staff. Communication is a continuing process, not simply a single meeting or a statement issued after an investigation is complete.

Leadership must create conditions in which staff can disclose appropriately and understand the requirements for the incident concerned. The policy also explains the relevant legal protections, while keeping empathy and practical support central. Its purpose is to combine procedural compliance with trustworthy communication and learning, rather than allowing legal or organisational processes to displace the needs of those affected. Read document

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