NAVIGATING THE NHS | MODULE 06

Starting work safely

Turn an offer into a safe first day through written scope, induction, access and named support.

- ✓ 22 min reading
- ✓ Full teaching, practical next steps and reflection
- ✓ Six practice questions with answers and explanations
- ✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

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Using this module

Independent education

This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

Your first shift should not be a mystery. Before starting, confirm the rota, clinical area, expected level, senior cover, induction, systems access and what to do when you need help.

Three next actions

- Ask for the rota, reporting location, induction plan, supervisor and first-shift expectations.
- Confirm that identity, occupational health, right-to-work, payroll and registration checks are complete.
- Do not undertake unfamiliar or unsupported work simply because the service is busy.

Learning objectives

- Prepare the practical systems, scope and supervision needed before the first clinical shift.
- Use the first 90 days as a staged transition with early review rather than a single induction event.
- Recognise when unfamiliar work, poor access or inadequate support creates a patient-safety risk.

Before day one: make the first shift knowable

Obtain the job description, rota, reporting location, named supervisor and induction schedule. Confirm employment checks, occupational health, payroll, identity, right to work, GMC status and professional protection. Ask which clinical area you will cover, at what level and who provides senior help during each part of the rota.

Access is a safety issue. A doctor who cannot open the record, request investigations, prescribe, contact switchboard or enter a clinical area cannot work normally. Confirm accounts, smartcards or identity systems, prescribing authority, building access and out-of-hours arrangements. If essential access is missing, tell the responsible senior and agree a safe temporary arrangement rather than borrowing credentials.

- Written role, rota, sites and first-day location.
- Named clinical and educational support.
- Records, results, prescribing and referral access.
- Emergency numbers and escalation route.
- Employment, payroll and professional checks.

Induction has organisational, departmental and individual layers

Corporate induction introduces the organisation, but it rarely prepares a doctor for the clinical job. Departmental induction should cover patient flow, handover, prescribing, referral routes, escalation, documentation, investigations, incident reporting, safeguarding, equipment and local risks. Out-of-hours work needs its own orientation because staffing and access differ.

Individual induction connects the role to your experience. Review recent practice, unfamiliar procedures, local system knowledge and expected autonomy. Agree what you may do independently, what needs direct or indirect supervision and how the scope will be reviewed. A signed competency list is not useful if it was completed without observation or honest discussion.

- Organisation: policies, mandatory systems and employment processes.
- Department: clinical pathways, people, places and risks.
- Individual: capability, scope, support and development plan.
- Out of hours: reduced staffing, escalation and practical access.

Work safely during the first shifts

Use structured assessment, clear documentation and early escalation. Ask how local teams communicate urgency and which electronic queues or referral systems are monitored. NHS language can hide assumptions: 'refer', 'discuss', 'board round', 'medically fit', 'escalate' and 'senior review' may have local operational meanings. Clarify them rather than pretending familiarity.

Do not undertake unfamiliar work solely because the service is busy or another doctor says everyone does it. Explain the limitation, take the steps you can safely perform and seek appropriate support. When the mismatch is repeated, document it through supervision or the correct safety route so that the solution is organisational rather than left to individual improvisation.

- Confirm patient identity, urgency and immediate risks.

- Know who owns the decision and follow-up.
- Use closed-loop communication for critical information.
- Document advice, escalation and outstanding actions.
- Ask for review when response or diagnosis remains uncertain.

Adapt communication, consent and documentation to UK practice

Good communication includes checking understanding, using an interpreter when needed and respecting the patient's role in decisions. Family members may provide support but should not automatically replace a professional interpreter or the patient's own decision. Capacity is decision-specific and time-specific; consent is not a signature detached from information, alternatives and voluntariness.

Write records that allow another clinician to understand the assessment, reasoning, plan, communication and follow-up. Avoid unexplained abbreviations and retrospective reconstruction. If you add a late entry, label it accurately. Learn local documentation standards and the professional guidance that applies across the UK.

- Introduce yourself and your role accurately.
- Check communication needs and understanding.
- Explain material benefits, risks and alternatives.
- Assess capacity for the particular decision when required.
- Record reasoning, advice, escalation and safety-netting.

Use reviews at two weeks, six weeks and 90 days

A planned early review asks whether access, rota placement, supervision and scope are working. At around two weeks, resolve practical failures and urgent learning needs. By six weeks, review case mix, feedback, wellbeing and evidence. By 90 days, agree the continuing scope, development objectives and what support or job-plan change is required.

Keep the discussion specific. 'Settling in well' is not enough if prescribing access failed for ten days or the rota requires unsupported cross-cover. Bring examples, feedback and questions. The purpose is not to prove you need no help; it is to demonstrate safe development and make organisational responsibilities visible.

- Two weeks: access, induction, rota and immediate safety.
- Six weeks: feedback, capability, workload and wellbeing.
- Ninety days: agreed scope, development and evidence plan.
- Escalate earlier when risk cannot wait for a scheduled review.

When induction or support is inadequate

Raise a clear, factual concern with the supervisor or responsible manager: describe the missing support, the work affected, the risk and the practical action needed. Separate an inconvenience from an immediate safety threat. If the issue affects current patient care, use the urgent clinical escalation route first; employment or education routes can follow.

Keep a contemporaneous record that avoids patient identifiers outside approved systems. Seek help from medical education, the SAS or LED lead, guardian or speaking-up service, medical staffing, a trade union or professional defence organisation as appropriate. The correct route depends on whether the problem is clinical, educational, contractual, discriminatory or regulatory.

- State the fact and patient or service consequence.
- Ask for a specific safe action.
- Record response and remaining risk.
- Use the next proportionate route if unresolved.
- Obtain individual advice for serious or formal matters.

Common mistake

Avoid this	Do not confuse willingness to help with permission or competence to perform unfamiliar work. Ask, escalate and agree the safe boundary.

Pause and reflect

If you were placed on the rota tomorrow, which system, local process or clinical expectation would you be least ready to manage safely?

Takeaways

- Access, induction and an agreed scope are patient-safety requirements.
- A safe doctor asks for help and makes unsupported work visible.
- The first 90 days should contain planned reviews, not one induction followed by silence.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. Your prescribing access does not work on the first shift. What is safest?

A. Prescribe under another name.

B. Tell the responsible senior and agree a safe documented temporary process.

C. Borrow a colleague's login.

D. Wait until the next day without informing anyone.

2. Corporate induction is complete. What else is required?

A. Only mandatory e-learning.

B. Departmental and individual induction linked to the actual role and experience.

C. A consultant title.

D. Nothing.

3. You are asked to perform an unfamiliar procedure because the department is busy. What should you do?

A. Refuse all involvement.

B. Ask a junior colleague to do it.

C. Proceed to avoid delay.

D. State your limit, provide safe care within scope and obtain appropriate supervision or alternative help.

4. A relative offers to interpret a complex consent discussion. What is the best general approach?

A. Ask the relative to sign consent.

B. Always accept.

C. Use appropriate professional interpreting support unless an urgent exception or informed patient preference justifies otherwise.

D. Proceed without interpretation.

5. What should a two-week review prioritise?

A. Annual leave for next year.

B. Access, induction, rota, supervision and immediate safety issues.

C. Five-year career planning only.

D. Consultant application.

6. Inadequate supervision is affecting current patient care. Which action comes first?

A. Use urgent clinical escalation to protect the patient, then address the wider issue.

B. Resign immediately.

C. Post about it online.

D. Wait for appraisal.

Answers and explanations

1. B — Tell the responsible senior and agree a safe documented temporary process.

Credentials must not be shared; missing access needs active risk management.

List essential access and the escalation contact before the next shift.

2. B — Departmental and individual induction linked to the actual role and experience.

Safe clinical work depends on local pathways and an individual scope review.

Use the three-layer induction checklist.

3. D — State your limit, provide safe care within scope and obtain appropriate supervision or alternative help.

Service pressure does not remove professional limits or the duty to seek support.

Prepare a clear phrase for escalating scope limitations.

4. C — Use appropriate professional interpreting support unless an urgent exception or informed patient preference justifies otherwise.

Complex decisions require reliable communication and protection of the patient's autonomy.

Review local interpreter access and consent guidance.

5. B — Access, induction, rota, supervision and immediate safety issues.

Early practical failures need correction before they become normalised.

Complete the two-week page in the First 90 Days workbook.

6. A — Use urgent clinical escalation to protect the patient, then address the wider issue.

Immediate patient protection precedes longer-term employment or educational resolution.

Identify both the urgent clinical route and the later organisational route.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

GMC: Good medical practice
UK / nation-specific · https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice

NHS Employers: international recruitment toolkit
UK / nation-specific · https://www.nhsemployers.org/intl-kit

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