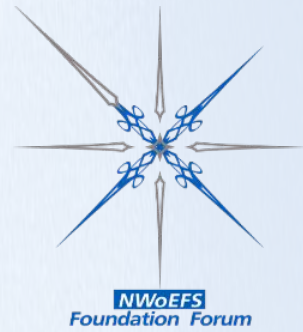




North West Foundation Handbook

*Produced in collaboration with the North West Foundation Forum,
with contributions from Foundation Doctors across the deanery*



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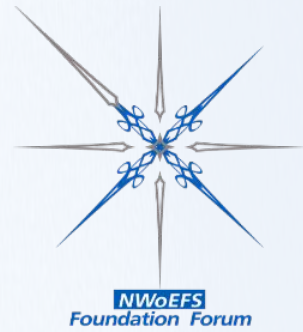
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Section 1



Foreword

Dr. Nomi Fischer

Introduction to the Handbook

The North West Foundation Handbook is a peer-led resource, produced by resident doctors in the North West deanery, for Foundation Year 1 (FY1) doctors starting work in the region in August 2026.

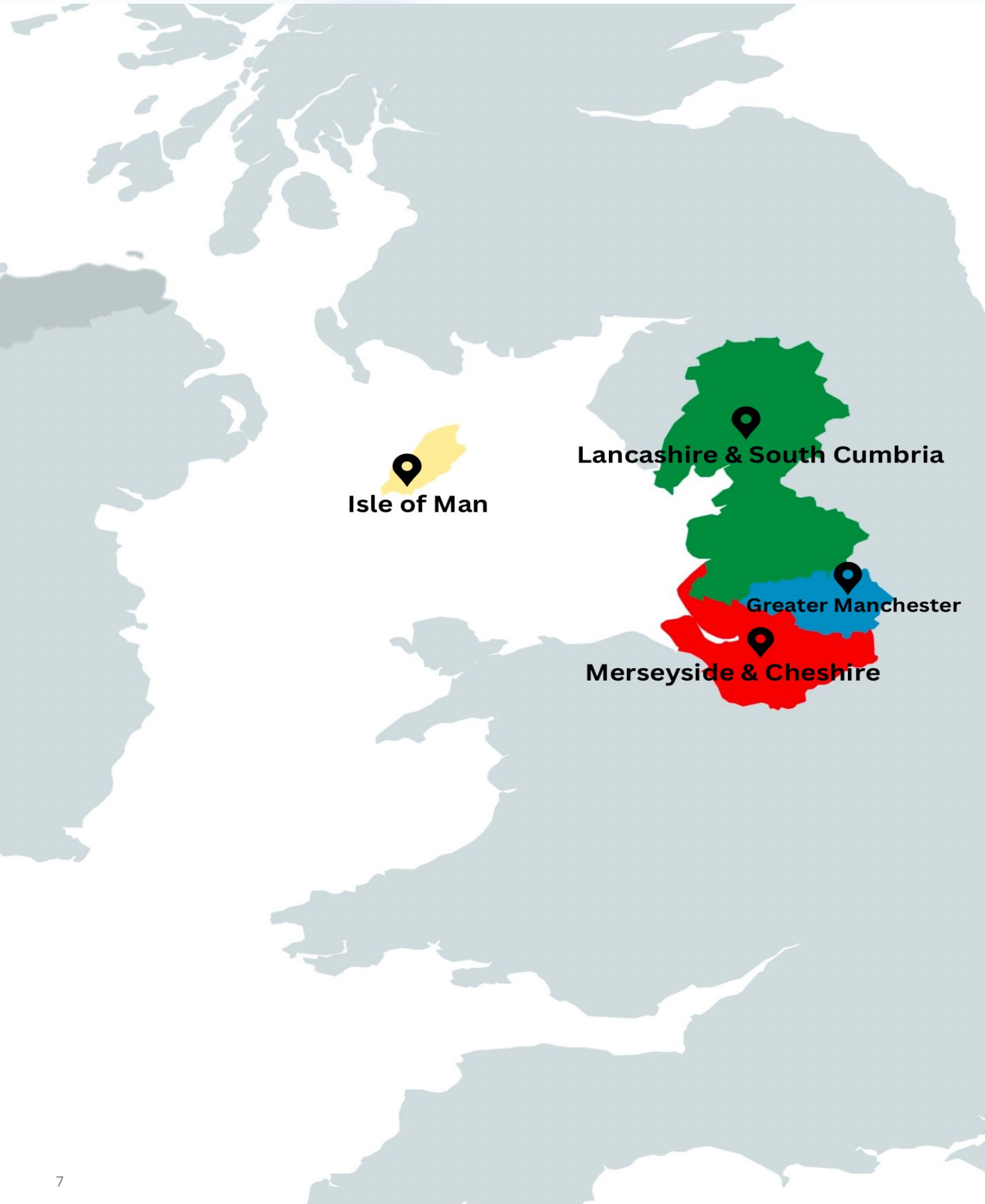
As foundation doctors working on a rotational basis, the changeover period is often one of great uncertainty and anxiety. This effect is worsened by poor or absent departmental inductions, leading to the feeling of being unnecessarily “thrown in at the deep end” and struggling to settle into a new department. This creates great frustration, as just when you feel as though you’ve become confident in your role and are familiar with the team, it is time to rotate once again. The Handbook was created to act as an adjunct to local inductions, aiming to provide information specific to foundation doctors working within the North West deanery, to ease the difficulties of the changeover period.

Following the release of its First Edition in 2026, the North West Foundation Forum will produce annual updates, ensuring that the handbook remains relevant and useful to FY1s starting work within the deanery.

For enquiries or feedback, please contact nwfoundationhandbook@gmail.com

Map of the North West Deanery

Dr. Khadija Ameir



North West Deanery

Dr. Khadija Ameir

Hospitals in the North West Deanery

The North West Deanery Covers:

- Greater Manchester
- Merseyside & Cheshire
- Lancashire & South Cumbria
- Isle of Man (*The Isle of Man is not part of the NHS. It is linked to the North West Deanery for medical training and has its own healthcare system called Manx Care*)

Greater Manchester	Merseyside & Cheshire	Lancashire & South Cumbria
Manchester University NHS Foundation Trust • Manchester Royal Infirmary • Wythenshawe Hospital • Royal Manchester Children's Hospital • North Manchester General Hospital Northern Care Alliance NHS FT • Salford Royal Hospital • Royal Oldham Hospital • Fairfield General Hospital • Rochdale Infirmary Other GM Trusts • Bolton NHS FT → Royal Bolton Hospital • Stockport NHS FT → Stepping Hill Hospital • Tameside & Glossop ICFT → Tameside Hospital • Wrightington, Wigan & Leigh FT → Royal Albert Edward Infirmary	NHS University Hospitals of Liverpool Group • Royal Liverpool University Hospital • Aintree University Hospital North Cheshire and Mersey NHS Foundation Trust • Warrington Hospital Mersey and West Lancashire Teaching Hospital NHS Trust • St Helens Hospital • Southport Hospital • Whiston hospital Other key trusts • Alder Hey Children's NHS FT → Alder Hey Hospital • Countess of Chester FT → Countess of Chester Hospital • East Cheshire NHS Trust → Macclesfield District Hospital	Lancashire Teaching Hospitals FT • Royal Preston Hospital • Chorley & South Ribble Hospital East Lancashire Hospitals FT • Royal Blackburn Hospital • Burnley General Hospital Blackpool Teaching Hospitals FT • Blackpool Victoria Hospital University Hospitals of Morecambe Bay FT • Royal Lancaster Infirmary • Furness General Hospital • Westmorland General Hospital
		Tertiary Centres

History of Medicine and Surgery in the North West

Dr. Phoebe Drew



Medical and Surgical Firsts

- **1824** – Manchester Royal School of Medicine opens as the first medical school in England outside of London
- **1847** – Dr. William Duncan is appointed the first Medical Officer for Health in the UK; in the role he pioneered public health initiatives and improved sanitation
- **1948** – Park Hospital (now known as Trafford General Hospital) is recognised as the first NHS hospital, opened by Health Minister Aneurin Bevan
- **1959** – Calpol is launched by Calmic Limited (based in Crewe), marketed as a sweet syrup formulation of paracetamol for children. It has gone on to become one of the most recognisable brands in the UK
- **1962** – Sir John Charnley performs the first modern total hip replacement at Wrightington Hospital
- **1970** – Tamoxifen is used for the first time as an adjunct treatment in breast cancer at The Christie cancer hospital in Greater Manchester
- **1978** – Louise Brown becomes the first baby worldwide to be born using IVF treatment when she was born via caesarean section at Oldham General Hospital
- **2025** – The Isle of Man becomes the first region in the British Isles to pass an assisted dying bill; the legislation is due to come into force in 2027

Public Health Policy in Industrial Cities of the NW

Throughout the late 19th and early 20th centuries, people moved from rural areas to developing industrial cities like Manchester and Liverpool. Increasing population density and overcrowded housing without the appropriate infrastructure led to major public health problems.

In Summer 1918 the UK was on the verge of an influenza pandemic thought to be brought back with soldiers fighting in World War I. Manchester was at especially high risk due to the increasing population and overstretched housing. By June 1918 incidences of flu were well established in Manchester and Salford causing businesses and schools to close due to ill health. Initially the government remained focussed on the war efforts, assuming the illness would only affect the elderly and infirm. Dr James Niven, Medical Officer for Health in Manchester, took a different approach, he had already built a reputation as an innovator in sanitation, pioneering health visiting and improving public water supply. He advised increased ventilation in houses and, where possible, isolation of unwell individuals. Dr Niven also ordered the closure of public crowded spaces such as factories and cinemas. These measures are widely credited with reducing the mortality from influenza in Manchester.

As a port city, Liverpool had strong connections with “tropical regions” through the shipping industry, transatlantic slave trade and British colonial rule, so the city faced unique public health challenges from non-indigenous disease being introduced to the population. In 1898 Sir Alfred Jones funded a Liverpool School for Tropical Medicine (LSTM). In the early years research was dominated by a colonial mindset, focussed on protecting the British Empire, its economy, and its workers from an overseas threat. Professor Brian Maegaith took over as Dean of LSTM in 1946 and began to shift the focus in light of post war globalisation; he is famously quoted saying “Our impact on the tropics should be in the tropics!” After World War II, an increase in international tourism and labour migration gave LSTM new purpose in public health beyond its colonial past. Professor Maegaith championed public health initiatives to educate the public on the risk of disease when travelling and encouraged airlines and travel agents to warn passengers about these risks. LSTM designed postgraduate programmes to educate healthcare professionals on imported disease, epidemic regions and incubation periods allowing physicians to narrow down differential diagnosis based on geographic history.

History of Medicine and Surgery in the North West

Dr. Phoebe Drew



Largest Asylum in Europe

In 1845 the government passed the Lunatics Act, which differentiated between prisoners and the mentally ill, imploring the construction of county asylums to house this newly classified patient group. Prestwich Hospital (originally called Second Lancashire County Lunatic Asylum) was opened in response to this act and by the turn of the century was the largest asylum in Europe with over 3000 patients. The institution was brought into disrepute when locum medical officer Montagu Lomas published an exposé titled “The Experiences of an Asylum Doctor” highlighting the inhumane but accepted practices in the specialty. The following outcry contributed to new legislation aiming to improve mental health care across the UK. In recent years, a memorial stone has been erected to commemorate former patient buried in unmarked graves in the grounds.

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Horus E-Portfolio Requirements

Dr. Megan Hassall

Introduction to Horus

- Horus eportfolio is the online platform used to upload evidence required to pass your ARCP (annual review of competence progression) during FY1 and FY2.
- Use the first month of FY1 to settle into your placement and then familiarise yourself with Horus and start writing up evidence.
- You will be allocated 2 hours of Self Directed Study Time every week to work on your portfolio (sometimes given as 1 full day a month) but you should also take advantage of quiet ward days.
- Requirements for ARCP can vary slightly between trusts so make sure you ask some FY2s at your trust or your foundation team when you start
- There are 13 curriculum points, grouped into three **HLOs (higher level outcomes)** that you need to demonstrate you have met.

Types of Portfolio Evidence

- ***Case Based Discussions (CBDs)** - documenting a discussion around an interesting case that you have presented to a senior - these signed by any doctor more senior than FY2, or ACPs and specialist nurses in their discipline.
- ***Mini-CEX** - an observed patient interaction which is mainly focused around communication - this has to be signed by a doctor more senior than FY2, ACP or specialist nurse
- ***Direct Observed Procedure (DOPs)** - an observed patient interaction which involves a procedure or skill e.g. bloods, cannula, ECGs, otoscopy, ABG, catheter etc. Signed by a doctor more senior than FY2, ACP or specialist nurse
- **Reflection** – these forms encourage you to reflect on any event of your choice and you can choose whether to keep them private or shared but only shared reflections will count towards ARCP, nobody has to sign them off.
- ***LEARN** form - this is a type of reflection which you can link to other evidence but it needs to be done with supervision
- ***Developing the Clinical Teacher (DCT)** – this can be used when you have been supervised by a senior delivering any form of teaching – has to be signed by ST1 or above
- **Personal Development Plan (PDP)** – you complete this on your own or with your supervisor at the start of each placement and list your personal goals that you would like to focus on for that placement and outline how you will achieve this. You can then mark this as achieved at the end of each placement.
- **Placement Supervision Group Feedback (PSG)** – you need to ask your clinical supervisor to send this out towards the end of a placement to gather feedback on your performance. You need signatures from at least three doctors more senior than FY2, senior nurses, ACP or other senior members of the MDT.
- **Team Assessment of Behaviour (TAB)** – you send this to 10 members of the MDT (at least 2 consultants, 1 other doctor more senior than FY2, 2 Nurses (band 5 or above), and 2 other HCPs/ foundation doctors) to gain feedback.
- ***Supervised learning event (SLE)**

Other portfolio evidence: Teaching others, Quality Improvement, Courses/Seminars, publications, exams, research.

The above is based on the UKFPO guidance- check with your trust, they may have more strict criteria on who can sign off SLEs.

Horus E-Portfolio Requirements

Dr. Megan Hassall

Portfolio Requirements

- You will need a PDP, clinical/educational supervisor start and end of placement form for each placement
- Minimum placement requirements vary depending on trust, usually a mixture of CBD, mini-CEX/DOPs and reflections
- Minimum annual requirements: 1x DCT, 1x satisfactory TAB, 1x satisfactory PSG and you also need to evidence involvement in an audit or quality improvement project
- You must map at least 3 pieces of evidence to each curriculum point/ HLO (higher level outcome). You can map each piece of evidence up to 3 times.
- You must write a summary narrative per HLO to demonstrate why you've met that competency. This should be updated each rotation

Top tips

- Keep up to date with horus- the longer you leave it to send out SLE forms, the more difficult is to get them signed off
- Tailor reflections and e-learning to the curriculum points you're struggling to hit.
- Use the language of the descriptors for each curriculum point when writing up your evidence to show how you've met the curriculum.

Please check the UKFPO guidance and your local policy- requirements as to who can sign your portfolio may vary slightly locally.

Specialised Foundation Programme

Dr. Shehza Shafeek

Introduction to SFP in the North West

The SFP provides opportunities for doctors to develop their research, teaching, and/or leadership skills, alongside achieving the core foundation competencies. In the North West (NW), in 2026, there are 63 SFP posts across 8 trusts. Liverpool and Manchester have a greater number of posts and more links to key research infrastructure such as their respective universities and the National Institute for Health and Care Research (NIHR).

The NW is unique in that the core SFP teaching days are regional instead of trust-based. Teaching days occur monthly for all NW SFP Resident Doctors to attend, with a different schedule for F1s and F2s. Each day focuses on either research, medical education or leadership, and content covered includes the basics that are then built upon. This ensures that resident doctors are exposed to all three tracks, building well-rounded academic clinicians.

There are 3 locations for teaching:

- Edge Hill University, Ormskirk
- Edge Hill University, Manchester
- The RCP Spine Building, Liverpool.

Although teaching is regional, there are still differences between trusts in terms of how the SFP is run, and facilities and funding available, so check your trust's website for more accurate information and FAQs.

Responsibilities as an FY1/2

- Attend regional teaching days (authorised absences include annual leave, on-call, zero day, nights)
- Ensure you are still meeting your core competencies to pass ARCP
- In FY1, follow your trust protocol and deadlines for confirming your academic project, including confirming supervisors, project aims and timetables.
- In FY2, undertake a 4-month project within your SFP track, engaging with academic medicine, showing commitment to your area of interest and hopefully, achieving some presentations/posters/publications.

Opportunities to take up

• **PGCert with Edge Hill Uni**

The Foundation School will offer funding support for a relevant PG Cert as part of a leadership or education programme. The School will typically look to fund 1 module with further funding being subject to budgets. Available and suitable PG Certs should be discussed with your FPD in the first instance.

• **Become your trust's SFP rep**

• **Become a regional NW SFP rep**

2 FY1s and 2 FY2s work with the Teaching Lead at Edge Hill and the Dean of the NW to deliver projects to improve SFP teaching, opportunities and resident doctor experience.

• **Collaborative cross-trust research projects**

Share workload and increase chances of publications by working on papers with other NW SFP resident doctors.

• **Submit to various NW and national conferences**

SFP Showcase, National ACF Conference, NW Sharing Best Practice Conference, National Foundation Doctors' Presentation Day to name a few.

Enhance Programme

Dr. Sarah Hobbs

Introduction to Enhance

Enhance is a programme developed by NHS England to support foundation doctors in developing transferable skills, behaviours, and attitudes that are valuable across all specialties and future applications. The learning outcomes are aligned with the UK Foundation Programme Curriculum, and certification is provided on completion.

The Enhance programme covers six core themes which are split into modules:

- Person centred practice
- Complex multimorbidity
- Systems working
- Population health
- Social justice and health equity
- Environmental sustainability

There is also a contextual leadership summary module to bring together key learning from the enhance programme. You do not need to complete modules in a fixed order, and they can be worked through alongside different clinical rotations.

Roles and Responsibilities as an FY1/2

As an FY1/FY2 on the Enhance pathway, you are expected to:

- Attend Enhance teaching sessions organised by your trust
- Attend regional Enhance workshops where available
- Engage with the Enhance module workbooks, these workbooks include:
 - Suggested online learning
 - Suggested clinical learning activities
 - Module learning outcomes
- Complete Reflection on Enhance Activities and Learning (REAL) forms on Horus. This can be used to summarise your evidence for completing that enhance module and reflect on your learning. It is recommended to complete a REAL form per enhance module.
- Undertake a quality improvement activity related to an Enhance theme (local expectations may vary)

Engagement and reflection upon enhance experiences are as important as attendance.

Getting started with Enhance

To get started with enhance:

- Review the Enhance programme handbook
- Discuss with your hospital/trust regarding the enhance placements they have planned for you to undertake
- Start to work through enhance modules
- Consider using Enhance learning outcomes when reflecting or completing supervised learning events (SLEs)

Individual trusts have differing approaches- some may allocate you time in which to complete your additional enhance activities, however others may not- clarify this early, and plan ahead to utilise your time well. Options for this include developing your generalist skills, or gaining exposure in teaching, leadership, audit/QIP, specialties of interest to you.



Resources

Working as an IMG in the North West

Dr. Mehek Mittra

Introduction

Firstly, welcome to the NHS. From a fellow IMG Foundation Doctor, the start of this new chapter will feel both exciting and, at times, overwhelming. The transition from medical school to clinical practice involves adapting not only to a new healthcare system, but also to different clinical practices, workplace culture, and professional expectations.

For many IMGs, the first few months represent a steep learning curve- understanding the structure of the NHS, becoming familiar with hospital electronic systems, and building confidence in clinical decision-making. However, with the right support, encouragement, and a proactive approach, this transition can be both manageable and highly rewarding. The North West Deanery offers a diverse and supportive training environment, with exposure to a wide range of clinical settings, patient populations, and learning opportunities.

Roles and Responsibilities

As a Foundation Doctor, your role is usually ward based and forms a vital part of the multidisciplinary team:

- Participating in ward rounds and documenting plans clearly.
- Ensuring jobs are prioritised effectively.
- Requesting and interpreting investigations, eg. bloods, imaging etc.
- Completing discharge summaries and ensuring continuity of care.
- Responding to urgent bleeps and escalating to seniors early and appropriately during on calls.
- Practise patient-centered care; liaising with nursing staff, pharmacists and allied health professionals.
- Engaging in teaching, audits and QIPs

Important Knowledge / Skills

1. Understanding the NHS System
 - Referral pathways and MDT workings
 - Knowledge of local trust guidelines and trust-specific policies
 - Effective use of hospital electronic systems (e.g. prescribing safety, accessing patient records)
2. Communication Skills
 - Effective and clear documenting, escalating concerns to seniors
 - Breaking bad news and handling difficult conversations sensitively
 - Understanding cultural differences in patient interactions
3. Clinical Prioritisation and Time Management
 - Managing multiple tasks efficiently during busy shifts
 - Recognising and responding to acutely unwell patients
4. Safe Prescribing
 - Familiarity with commonly used medications in the NHS
 - Awareness of guidelines (e.g. antibiotics, anticoagulation, fluids)
 - Regular use of resources such as the BNF

Working as an IMG in the North West

Dr. Mehek Mittra

What I Wish I Knew As A New IMG

I wish someone had told me is that you are not expected to know everything. Your role is to be safe, to ask questions, and to learn every single day. In the first few weeks, even simple tasks can feel daunting- writing notes, prescribing, or managing your bleep. But with time, repetition, and experience, things begin to fall into place. What feels unfamiliar now will soon become second nature. It's also important to remember that you are never alone. Your seniors expect you to ask for help, and escalating concerns early is seen as a strength, not a weakness. Patient safety always comes first, and good doctors are those who recognise their limits. There will be busy days, difficult shifts, and moments of self-doubt. But there will also be small wins- your first confident patient review, your first thank you from a patient, your first moment of realising, "I can do this." Hold on to those moments. Be kind to yourself. You are learning, growing, and adapting to a completely new environment. Remember why you started. You've worked incredibly hard to get here- and you absolutely deserve to be here.

Working Less Than Full Time

Dr. Naima Malik

Introduction to Less Than Full Time (LTFT)

Foundation Doctors may apply to undertake Less Than Full Time (LTFT) training; however, LTFT can only be undertaken with the approval of the employing Trust. Approval is mandatory and will be subject to local workforce, service and rota requirements. Doctors should not assume that an LTFT arrangement will be available and are advised to discuss this with their employing Trust as early as possible.

Where LTFT training is approved, doctors commonly work at 80% (four days per week) or 60% (three days per week). As training is competency-based and programme requirements must still be met, the duration of Foundation training will normally be recalculated in proportion to the reduction in working hours. For example, working 80% LTFT will lead to a 15-month F1 and F2 training programme.

Working LTFT can allow resident doctors to maintain a more balanced work-life schedule however, there are some things to keep in mind when applying – see below.

Frequently Asked Questions

How do I apply?

There is a form on the Foundation School website which needs to be completed by yourself & your Foundation Programme Director and then sent to NHS England North West School of Foundation Training. This should be done at least 16 weeks before your start date of less than full time working. If you are an incoming F1 then please apply within 2 weeks of receiving your Oriel match. If you want to return to full time for FY2, fill out another form 16 weeks before changeover

Can anyone apply?

Yes, however you will be asked to select a reason for doing so from the following: disability/ill health, caring responsibilities, welfare and wellbeing, unique responsibilities, religious responsibilities, non-medical development, career development. Welfare and wellbeing is becoming a much more popular and supported reason for working LTFT.

What about my salary?

Your salary will be adjusted according to the number of hours you work and the number of on calls you do.

When will I finish my training?

Working LTFT means your end date could be impacted. If you are LTFT in FY1 you will have to extend the period of your training– e.g. someone working at 60% would have to complete an extra 8 months of training. If 80% only in FY2 you may be eligible to accelerate your training and complete it alongside your full-time colleagues. To do this you must prove via horus that you demonstrate 'exceptionality':

- Exceed “competent” and “proficient” criteria in all key dimensions
- Documented evidence (SLEs, feedback, supervisor reports) supporting exceptional performance in each dimension
- Demonstrated leadership, teaching, or quality improvement beyond your expected level
- Demonstrated a measurable positive impact on patient care and the learning environment
- Evidence of supervisor commendations or top-tier SLE feedback

Working Less Than Full Time

Dr. Naima Malik

Frequently Asked Questions continued

If you are able to prove all the above, you may be considered 'exceptional' and considered for accelerated completion, which is reviewed at deanery level. For more information on this, reach out to your supervisor and FPD early, and read the full guidance on the deanery website. The key to proving exceptionality is planning in advance to ensure that your horus is jam packed and proves that you go above & beyond.

Types of Leave Explained

Dr. Sarah Brunton

There are many types of leave that you are entitled to during the Foundation Programme, and it is important to be aware of them so that you can utilise them properly. Make sure to check your local policy.

Annual Leave (AL)

- You are entitled **9 days** of annual leave per rotation, if you are LTFT this proportionately reduces.
- You need to use all 9 days within the rotation (**use it or lose it**). You may be allowed to carry over days: ask both your current rotation and your next rotation first and be aware that it is not guaranteed.
- You cannot take AL on an on-call shift. You would have to swap this on-call shift with a colleague's 'standard day' and then take AL on this.
- Every department and trust has different ways to apply for annual leave – ask & familiarise yourself.
- You should apply for leave **at least 6 weeks** before. If you are having trouble getting leave accepted, speak to your supervisor, your BMA representative or your foundation programme director (FPD)
- For life-changing events (as defined by the doctor e.g. your wedding), your employer must grant you the requested leave, as long as you have given enough notice.

Sick Leave

- If you are unwell on a workday, follow your hospital's policy on calling in sick. This usually involves informing your department and the site rota/ workforce/ staffing team.
- If you are on call, it is necessary to call the on-call consultant to inform them.
- If you are doing clinics, try and let the appropriate people know as soon as you can so they can make arrangements for this.
- You must inform workforce when you return to work after sickness, or it may affect your pay.

Self-Directed Time (SDT)

- SDT is time formally included in your schedule for you to carry out **non-clinical activities related to your curriculum or career exploration**, such as working on ehorus portfolio, meeting with supervisors, carrying out QI work, exploring career opportunities.
- You do not have to be on site for this.
- Arranged differently in each trust & rotation. Generally, you should have 2 hrs/week, usually grouped and taken as full days. Sometimes appointed to you, sometimes you can choose when to have this.

Study Leave

- Check your local trust policy for your study leave allowance as this can vary, but you typically get up to **10 days of Study Leave** for personal use of career exploration and personal development across FY1/2.
- These can be used for: taster weeks/ days, courses, conferences, exam revision
- The MSRA exam is officially classed as a speciality 'application assessment' nationally, so local policy varies on whether it is possible to take study leave to revise for it- check with your trust
- Generally, applying for Study Leave requires approval from your Educational Supervisor and then from the Foundation Team, at least 6 weeks before.
- You may be eligible to apply for expenses to help finance your study leave- check your trust policy

Professional Leave

- Professional leave should be used for any work outside of the requirements of the curriculum and/or the employer.
- This can be used for things such as:
 - Leave to take professional exams
 - Job interviews
 - Professional work for a role eg trade union rep
- You should provide rota coordinators with as much notice as possible, principles are generally as with study leave

Types of Leave Explained

Dr. Sarah Brunton

Bank Holidays (BH) and Time Off in Lieu (TOIL)

- In addition to AL, you are entitled to public holidays.
- For Bank Holidays, if you are on a 'normal day', you will usually be off.
- If you are on-call, you will be working the BH and **get a day back in-lieu** (ensure that you make the rota coordinator aware and ask for it back, it works like annual leave). You may have to take this lieu-day off close to the BH, depending on the rota coordinator- ask to be sure.
- This is irrespective of how long you work on that day, e.g. a night shift on Christmas day to Boxing Day = 2 days off in lieu.
- You are also entitled a lieu-day if you are scheduled for a zero day on a BH.
- If you have worked more than your scheduled working hours, and you **exception report** this, you may be entitled to this time off in lieu (or payment).

TOOT (Time Out of Training)

- This is the total number of days you have been absent throughout the rotation/year, which includes Sick days, Industrial Action, Parental Leave, Compassionate leave, and any other unpaid/unauthorised leave.
- Study leave, SDT and Annual leave are not counted in your TOOT.
- The threshold is **20 days/year** for Resident Doctors. If you are approaching this threshold, you should raise it with your supervisor or your Foundation School Director early.
- Whilst strike days are counted as TOOT, you cannot be held back by ARCP if your strike days take you to over 20 days TOOT.

References

Mind the Bleep: 'Leave'
 BMA: 'Leave'
 BMA: 'Study, Professional and Special Leave'
 NHS Health Education England: Self-Development Time (SDT) FAQs for Foundation Trainees (and their Supervisors)
 BMA: 'Maternity leave pay entitlements under the NHS scheme'
 BMA: 'Paternity Leave for Doctors'
 Messly: Your Rights on Annual Leave
 BMJ Careers: A Doctors Rights: Annual Leave
 BMA: 2024 Pay Deal for Resident Doctors Working in England

Compassionate/Special Leave

- This is leave for urgent or stressful circumstances, such as bereavement or family emergencies.
- In some circumstances, this may be unpaid leave.
- If you're having trouble getting this approved, speak to your supervisor. Make sure to prioritise your wellbeing.

Maternity/Paternity Leave

- Maternity – up to 52 weeks, but not all on full pay.
- Eligibility: 12 months of continuous service with one or more NHS employers at the beginning of the 11th week before your expected week of childbirth (breaks in service 3 months or less ignored)
- You must notify your employer of the due date at least 15 weeks before, and let them know your leave period with at least 28 days' notice.
- Paternity – 2 weeks, either continuous or split.
- Eligibility for statutory paternity pay: 26 weeks of continuous service, must be met by the end of the 15th week before the baby is due.
- Eligibility for NHS full paternity pay: 12 months of continuous service, met before the start date of your leave or at the beginning of the week the baby is due

Zero Days

- Technically not leave, but these are **rest days** following or before your on-call shifts.
- It can be beneficial to look at your rota and tag your AL on after these dates to optimise your leave period.

Taster Days

Dr. Anna Murphy

What are Taster Days?

Taster days are short placements (usually one to five days) in a speciality of your choice; they aim to provide experience in areas that you haven't worked in during your FY1 / FY2 rotations. They provide the opportunity to explore a specialty that you may be interested in and allow you to gain insight into the day-to-day work and lifestyle of a department by shadowing senior staff. It is a great time for asking questions to resident doctors and consultants about their job, providing valuable insights to guide your decision making towards future career options.

How to arrange Taster Days

When you are encouraged to take taster days my vary by trust- reach out early to find out what is recommended locally. It is easiest to arrange taster days through your own hospital; however, they can also be organised at different hospital if your trust doesn't offer the specialty you want - these usually require approval from your foundation programme director.

Taster days are self arranged. You can start by contacting your educational supervisor, identifying a speciality and thinking about your objectives. You then need to contact a consultant within that department and arrange a time for you to go for your taster. At the same time as this, you will require approval from your rota co-ordinator to approve these days off as study leave. Taster days are taken out of your study leave allowance for FY1-FY2.

How to make the most out of your Taster Days

Taster days can be a great opportunity for both learning about the specialty you're interested in, as well as for boosting points towards applications (it helps to tick the box for commitment to specialty). It is important to keep in mind that specialty applications open in the October of FY2, so it is good to arrange your taster for before this date. Whilst shadowing, you can ask to gain experience in a variety of areas such as ward work, clinics, procedural skills and MDT working. Don't forget to complete a reflection in your Horus portfolio afterwards, and use this time to think about whether you think the specialty is suited to you.

Specialty	Specialist trusts within the North West
Cardiology / Cardiothoracic surgery	MRI, Liverpool Heart and Chest, Blackpool Victoria
Neurology / Neurosurgery	Salford Royal, The Walton Centre, Royal Preston
Paediatrics	Royal Manchester Children's, Alder Hey
Oncology	The Christie, Clatterbridge
Trauma	Salford Royal, Aintree, Royal Preston

Communicating with D/deaf patients

Dr. Sophie-Rose Ekitok



Introduction to British Sign Language and Deaf Awareness

As a doctor treating a wide range of patients, developing Deaf awareness is an essential part of providing safe and fair care. British Sign Language (BSL) is the main language used by many Deaf people in the UK and it is not the same as Makaton or Sign Supported English.

BSL is a recognised national language with its own grammar and syntax. It is not a visual translation of the English language but another language entirely.

This means that writing English words on paper or spelling out letters is not an effective replacement for communication since you would be using a completely different language. You may also meet BSL users who have experienced language deprivation. This often happens when someone grows up as the only D/deaf person in a hearing family and has limited early access to fluent BSL users. This can affect how they express symptoms or understand health information. It is vital to arrange a qualified BSL interpreter, either in person or via video call, every time you communicate with a BSL user. This should be treated with the same standard of practice you would apply for any spoken language, i.e. Urdu.

Deaf awareness matters in healthcare as Deaf patients often experience poorer health outcomes and higher rates of undiagnosed long-term conditions such as type 2 diabetes and hypertension. These differences are linked not only to health literacy but also to reduced access to education and communication barriers. This is especially relevant in areas where socioeconomic disadvantage is more common. Here are some tips on becoming a Deaf aware resident doctor.



SignHealth Resources



BSL courses



Manchester deaf
centre

How to Make a Difference as a “Deaf Aware” Resident Doctor

Step 1: Set the Scene

- Ask the patient **how they prefer to communicate** and facilitate this as much as possible otherwise the trust is failing to meet a legal requirement (Accessible Information Standard, 2016).
- D/deaf patients should be placed in a room if possible as background noise can interfere with communication and compromise history taking and review: inform your matron and bed managers
- Ample lighting
- Ensuring admin and clinical staff are aware (use lights on/off rather than knocking to gain attention)

Step 2: Arrange the interpreter

- Contact via switchboard
- Find out what your trust's BSL mobile and direct call lines are
- Maintain good eye contact whilst talking even if interpreter is present

Step 3: Start Signing

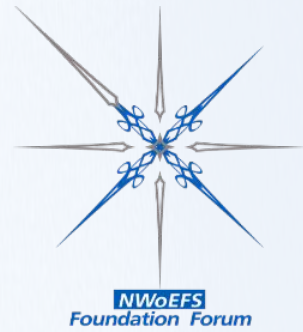
- Start an introductory course or Level 1 BSL, find local sessions on the Signature website
- Look on the SignHealth website for videos on health education (i.e. T2DM explanation)- these can be very useful for safety netting!

Northern Care Alliance contact details

- BSL Mobile Text: 07966 003540
- Direct BSL Line: 0161 656 1917 or 0161 627 8770

Glossary

- **D/deaf** — “Deaf” (capital D) refers to people who identify as part of the Deaf community and use BSL as their main language. “deaf” (lowercase d) refers to those with hearing loss who do not identify as Deaf.
- **Hearing** — A person who does not have hearing loss and mainly uses spoken language.



Section 2



Getting involved with Research

Dr. Alastair Paterson

Why get involved?

Research can be viewed by some as a bit of a headache, and you may have bad memories from projects at university that seemed overly complex, poorly supervised or not all that interesting. If this is you, this page aims to change your perceptions. If you like research, then great! Hopefully this article will help you figure out the next steps on your journey.

Being involved in research as a doctor is a creative and rewarding pursuit. It also adds a parallel skill to your development. This is relevant for specialty training applications, but it also helps you structure your thinking and improves your interpretation of clinical data. Being involved in research as a Foundation Doctor opens opportunities within sub-specialties and could open the door to an Academic Clinical Fellowship (ACF). ACFs are doctors in specialty training where 25% of their time is protected for research. Many of these doctors go on to do PhDs alongside clinical work

How to get involved

Find an area of clinical practice you are interested in. It's ok to shop around and work in different specialties or with different supervisors whilst you find what interests you, or who you would like to work with.

Ask yourself - are there any questions in your specialty that aren't well answered? Are there any unsolved problems? Is there something that interests you that you want to learn more about?

Find a supervisor and discuss your ideas for a project. Ask them for ideas if you aren't sure – most consultants or Professors have ideas they want to research, but not the time to do them. Look for research active doctors on ResearchGate or Google Scholar to see what people are researching.

Projects to get involved in

So where can you start? Research is a very broad church, and not all projects look the same. It requires writing, synthesis, analysis, idea generation, strategy, and many other skills. Think about skills you have already, or ones you want to learn. Are you better with languages and words than numbers and stats? Maybe start with a literature review over a sub-group analysis. If you already have research experience, where do you want to go next? What methodology do you want to add to your skillset? You don't have to start with an RCT. You can start by writing up a project that for someone that has already been done, or submitting an opinion piece to the BMJ.

It's worth being clear at the start what you would like out of a project (e.g. named authorship on a paper), how much time you think you can give, and agree a rough deadline (as things easily drift!)

If you have a few projects or publications under your belt already, try collecting different methodologies, stretching yourself with new skills and even building an identity in a research area by concentrating several papers in one area. You never know, you may get invited to write reviews or to peer-review someone else's paper!

Getting involved with Research

Dr. Alastair Paterson

Summary

Research is a skill that any clinician can learn. It can enhance your CV, improve job prospects and is very rewarding when papers get published. It encourages you to think outside the box, work creatively and collaboratively, and enhances your clinical ability. Any clinician can do research. If you think of a question without an answer, then you are the best placed person to find it!

Involvement in Teaching

Dr. Beriz Abdullah

Why is this important?

- HLO 2, FPC 10 is “Teaching the Teacher”¹. To receive a satisfactory outcome for ARCP, you must demonstrate appropriate and varied teaching experiences suitable for your level of practice.
- GMC guidance on *Good Medical Practice* advises under domain one, that all clinicians should be competent in all aspects of their work including research and teaching where applicable².
- Evidence of teaching experience and feedback on teaching can be a portfolio requirement for various specialties in medicine when applying to specialty training.
- Teaching experience is valuable in strengthening your CV for future job applications.
- Teaching and learning are fundamental aspects of medicine. We’ve all been medical students on the recipient end of valuable teaching encounters. This is an opportunity to share your knowledge and experiences for the improvement of our medical workforce.

How can I get involved as an FY1/2?

- Contact the educational fellows in the undergraduate team, for your base hospital, to become involved in medical student teaching.
- Contact the postgraduate team to become involved with delivering teaching for F1 and F2 clinicians.
- Formal teaching for medical students on rotation in your department – can raise this with your Clinical supervisor.
- Informal/Bedside teaching – organized independently or with the support of your clinical supervisor.
- QIPs/Audits may lead to opportunities to deliver teaching – discuss with your project supervisor.

Key tips and advice to success

- Take initiative, if you see an area for improvement in the teaching offered contact the education department, without action we won’t achieve progress.
- Keep a record of feedback for teaching delivered. You can request this from the audience or supervisors in attendance
- Create a QR code that links to a form with a generic template for teaching feedback – easy way to collate feedback from various teaching sessions in the same place, without having to make a new form each time
- Gain experience in a variety of settings, including lecture style, small group teaching, simulation teaching or bedside teaching

Additional Opportunities for Teaching	Key Skills and Attributes
• Simulation teaching • Support medical students with required “sign offs”. This can include case presentations, examinations, procedural skills – <u><i>please check you are able to sign off for the skill</i></u> • Departmental teaching, journal club meetings, Audit and Clinical Effectiveness (ACE) days or Morbidity and Mortality Meetings	• Time management and organization • Clear and effective communication • Ability to adapt teaching to fit the audience • Enthusiasm • Approachability • Proficiency with IT and various learning platforms and styles • Maintaining clinical knowledge and skills

Involvement in Teaching

Dr. Beriz Abdullah

References

1. UK Foundation Programme Office. Curriculum resource. Foundation Programme. [cited 2026 Apr 9]. Available from: <https://foundationprogramme.nhs.uk/curriculum/curriculum-resource/>
2. General Medical Council. Good medical practice: Domain 1 – knowledge, skills and development. [cited 2026 Apr 9]. Available from: <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice/domain-1-knowledge--skills-and-development>

Example feedback form

Teaching

Dr XYZ

Date of teaching session

Day, month, year

Topic of teaching session

Short-answer text

What was good about the session?

Short-answer text

On a scale of 1-5 how useful was the session?

1 2 3 4 5

Not useful

Very useful

What didn't work well/what would you like to change about the session?

Short-answer text

Medical Leadership

Dr. Gabriel Brown

Introduction to Medical Leadership

Medical leadership is an essential part of being a foundation doctor, not just a role for senior clinicians. The GMC emphasises these responsibilities in *Good Medical Practice*, which states that doctors must contribute to safe systems of care, work collaboratively, communicate clearly, and take action when patient safety may be compromised. In everyday practice, this may mean speaking up about concerns, leading quality improvement projects, coordinating care, or supporting colleagues. However, there are also multiple organisations and activities available to foundation doctors to develop skills and experience of Medical Leadership. Developing leadership skills early in training helps foundation doctors build confidence, resilience, and the ability to explore non-clinical leadership responsibilities for future career development.

Examples of Leadership Roles for Foundation Doctors

North West Foundation Forum (NWFF)

- *Forum of 4 representatives per NHS trust in the North West. Based on sharing good practice, QIPs of training and empowering Foundation doctors to be agents for change. There are opportunities for subcommittee engagement and additional attendance at courses.*

BMA representative – *Advocates for doctors pay, working conditions and other union related issues.*

Mess Committee – *Organise social and wellbeing events. Improve working environment of resident doctors.*

Leadership Courses – *Structured training on leadership skills for personal and professional development.*

Resident Doctor Forums – *Meetings of doctors and senior leadership to raise concerns and give local updates.*

Important Knowledge

- You will be contacted by the F2 NWFF representatives from your trust at the start of the year with information on how to apply to be a representative.
- Learn who your local BMA representatives are and discuss options and timings for getting involved in meetings or becoming a representative.
- Engage in local mess activities, with the option of joining in junior roles as an F1 doctor
- Attend resident doctor forums to meet the local leadership team and engage in the management discussions of your local trust.
- You are eligible to use your allocated study budget on leadership courses such as INGENIX.

Common Leadership Examples	Key Skills
• North West Foundation Forum • BMA representative • Mess Committee • Leadership Courses • Resident Doctor Forums	• Communication skills • Good organisational skills to manage additional roles • Professionalism • An understanding of the wider healthcare management network

Quality Improvement and Audit



Dr. Mary Knowles

Introduction to Quality Improvement Projects and Audits

Audits and Quality Improvement Projects (QIPs) are clinical governance tools within the NHS that monitor care standards and drive continuous improvement. They are essential for **identifying issues, implementing changes, and measuring their impact** and are a shared responsibility across the NHS. As such, they form a core part of portfolio requirements.

What is an Audit?

An audit **compares** current practice against recognised **standards** (e.g., NICE, NHS, or local guidelines) to confirm whether practices meet these standards. Audits can be single cycle (assessing current practice) or closed loop (including re-evaluation of practice following interventions to assess improvement)

Example: Comparing VTE assessment compliance in a ward to hospital guidelines. A closed loop audit would include an intervention to improve compliance and a second audit to assess improvement

What is a QIP?

A Quality Improvement Project (QIP) focuses on **reviewing and designing** ways to improve a specific process or patient outcome. Unlike audits, QIPs do not need to follow an existing standard. They can create new ways to improve care.

Example: Aiming to improve patient information accessibility using the PDSA (Plan–Do–Study–Act) cycle. This involves assessing current barriers, selecting a specific problem, implementing a targeted intervention, and evaluating its impact. The cycle is then repeated to drive further improvement. QIPs often take longer due to the need to design interventions and achieve sustainable change.

Getting involved as an FY1/2

Step 1: Find a Project Idea

Ask consultants, registrars, or colleagues for project suggestions.
Identify areas in your department that could be more efficient or are frustrating.
Reflect on your own observations or challenges during your rotation.
Choose a topic you can realistically complete within your rotation.

Step 2: Register the Project

Submit your audit or QIP to the local audit/QI department to formalize the project.

Step 3: Collect Baseline Data

Gather initial information on current practice before making any changes. Involve colleagues to share workload.

Quality Improvement and Audit



Dr. Mary Knowles

Getting involved as an FY1/2 continued

Step 4: Compare and Analyse

Audit: Compare your data against recognised guidelines, policies, or standards.

QIP: Use baseline data to plan interventions and compare to standards if available.

Ask for help from colleagues, audit teams, or the QI department if needed for data collection or analysis.

Step 5: Plan and Implement Interventions

Design changes or improvements based on your findings. Implement them and monitor the results.

Step 6: Reassess and Present Findings

Audit: Re Audit to check if changes meet the standards.

QIP: Assess the impact of your intervention and whether it improved practice.

Present your findings locally or at a regional/ national conference for your portfolio.

eQIPped Platform

Dr. Arshia Akhavan-Mofrad

Introduction to the eQIPped platform

eQIPped is a quality improvement platform created by the North West Foundation Forum Academic Subcommittee. It is designed to enable doctors within the North West deanery to share audit and quality improvement (QI) ideas and to participate in projects both within and beyond their base trust.

eQIPped was developed following a 2024 survey which highlighted low engagement in QI and audit activities, as well as limited access to specialty specific and multicentre projects, particularly in smaller district general hospitals.

The platform aims to improve patient care by supporting high quality QI work, facilitating multicentre collaboration, and increasing access to projects across different trusts and specialties.

Why use eQIPped?

- Connects foundation doctors with consultants across the North-West region who are keen to supervise audit and QI projects
- Helps foundation doctors explore careers interests by accessing audit and QI projects in specialties not offered at their trust
- Encourages coordination of regional, multi-centre projects
- Facilitates development of skills in study design, data collection, teamwork, leadership, presentation, and portfolio development for specialty applications
- Access up-to-date lists of upcoming conferences and abstract submission deadlines in one place
- Participation in audit and QI projects are mandatory to pass ARCP requirements

How to Join eQIPped

- Scan the QR code below
- Sign-up with your work email and await approval
- Once approved, you will be able to view projects and supervisor emails on the platform



Useful Links

- BMJ Open Quality – QIP templates and published examples - <https://bmjopenquality.bmj.com/>
- SQUIRE Guidelines – International framework for reporting QIPs - <https://www.squire-statement.org/>

How to Use eQIPped

From the homepage, you can navigate to the following pages:

- **Search QI projects** - takes you to a search bar where you can filter QIPs by specialty
- **QI Project List** - takes you to the forum with available QI opportunities and supervisors to search
- **Recruit to your QIP** - takes you to a page to create your own forum post to advertise your QI project
- **Example QIPs** - takes you to abstracts for previous projects created on eQIPped
- **Conference list** – takes you to a page containing upcoming conferences, dates, and abstract deadlines
- **Meet the Team** - introduces you to the team behind eQIPped

Contact Us

Email eQIPped at: equipped.nw@gmail.com

North West Foundation Forum

Dr. Nonye Obi



What is the North West Foundation Forum (NWFF)?

The North West Foundation Forum (NWFF) is a resident doctor led forum, comprising 2 x FY1 and 2 x FY2 doctors from each hospital in the North West deanery. Each foundation doctor acts as a representative for their local hospital trust. This helps to ensure that the views of all foundation doctors are heard, and that there is fairness in the feedback and governance processes. The forum meets monthly to discuss best practice and highlight any issues that have not been resolved locally. By discussing this on a regional level, we can highlight how best to tackle challenges, offer support, and if necessary, raise it regionally to the Foundation School Director, Professor Paul Baker.

How does the NWFF work?

Representatives are elected by peers at the start of FY1 and usually serve until the end of FY2. Incoming representatives attend a one-day face-to-face training session introducing the forum and its operations.

The NWFF holds monthly in-person meetings in Manchester or Liverpool, usually on the last Tuesday afternoon of the month. Representatives receive professional leave and travel time to attend meetings.

The NWFF core committee is formed of FY2s, with the President and Vice-President also acting as FY2 UKFPO Foundation Doctor Advisory Board representatives. Two FY1 representatives are also elected as FY1 UKFPO Advisory Board representatives.

The forum includes several subcommittees, including Academic, Wellbeing, Teaching, Technology, Sustainability, and Conference groups. Subcommittees promote specific interests through projects, presentations, and conferences.

The benefits of NWFF

- NWFF is well supported by leadership ensuring representatives feel confident that concerns raised will be taken seriously and acted upon.
- Provides opportunities for representatives to contribute to improving foundation training across the North West.
- Provides leadership workshops to help representatives strengthen their leadership skills and develop into more effective medical leaders.
- An open environment to share experiences, discuss challenges, and exchange best practice ideas across trusts.
- Promotes realistic and collaborative approaches to implementing change based on resident doctor experiences.
- Recent NWFF projects have focused on:
 - Equitable access to training opportunities and procedures
 - Standardising foundation teaching across the North West
 - Foundation doctor wellbeing, including the MindYourself app
 - Improving communication technology within trusts
 - Sharing quality improvement projects and audits
 - Supporting LTFT resident doctors and clarifying portfolio/ARCP requirements
 - EDI teaching and Freedom to Speak Up initiatives.

The Green Guide for FY

North West Foundation Forum
Sustainability Committee

Introduction to the Green Guide

The Green Guide is a resource developed by the North West Foundation Forum (NWFF) sustainability subcommittee to support foundation doctors to embed sustainability into everyday clinical practice.

Aligned with the principles of the NHS Net Zero Plan, it highlights how healthcare professionals can reduce the environmental impact of their work while maintaining high-quality patient care.

The guide outlines the carbon footprint of common medications, investigations, and interventions, and provides simple, evidence-based strategies to promote more sustainable practice—from reducing waste and energy use to encouraging greener prescribing and diagnostics.

By equipping doctors with the knowledge and tools to act, the Green Guide aims to empower the next generation of clinicians to contribute to a more environmentally responsible and resilient NHS.



Scan to access the
Green Guide



British Medical Association (BMA)

The **British Medical Association (BMA)** is the trade union for UK doctors and medical students. The BMA represents doctors and acts as a local and national support system, providing advice on pay, working conditions, training and wellbeing.

How can the BMA help?

Doctors may contact the BMA when something has gone wrong, but support is available at any stage of training. The BMA can help with:

Pay and rota issues

Help with incorrect pay, rota compliance, exception reporting, zero days, study leave funding and understanding work schedules.

Working conditions and wellbeing

Advice on fatigue, safe staffing concerns, rest facilities, annual and study leave, and managing unsafe or unsupportive working environments.

Training and progression

Guidance on Foundation training requirements, portfolio concerns, sickness or parental leave, and support if training standards are not being met.

Professional support and representation

Advice and representation during complaints, investigations, disciplinary processes or serious incidents.

Contractual advice

Clear explanations of national terms and conditions of service, including working hours, pay banding and contractual agreements.

Local BMA representation

Each Trust has local BMA representatives who are also doctors and understand the issues that can arise during training. They can raise concerns for discussion, support colleagues, and act as a link between doctors and Trust management.

Details of your local BMA representative can be found on the British Medical Association website, once logged into your member account, under 'local representation'.

If you are unsure who your local representative is, the BMA can direct you via their general enquiries or advice services.

FAQs

How to join

Search bma.org.uk into your browser and click 'Join us' to start your membership.

Membership costs

BMA membership is discounted for Foundation doctors. The cost is tax-deductible and can be reclaimed through HM Revenue & Customs.

BMA Services	How to contact
General enquiries, employment and pension advice	- BMA online employment advice form on bma.org.uk/support or call 0300 123 1233 (call-backs during normal working hours).
Wellbeing support services – available at any time for doctors needing emotional or psychological support.	- 24-hour counselling and peer support: 0330 123 1245
Doctor Support Service - emotional support for doctors experiencing stress, including issues related to complaints or regulatory processes.	- Telephone: 020 7383 6707 (Monday to Friday) or email doctorsupportservice@bma.org.uk

No More Grey Wednesdays

Dr. Nonye Obi

What are 'Grey Wednesdays'?

The first day of work as an FY1 is a significant transition for newly qualified doctors. This influx of doctors is known as 'Black Wednesdays'. Former medical students are supported prior to this day with inductions and resources (like this handbook) to help adjust to the responsibilities of clinical practice. However, an additional challenge that is sometimes overlooked is the transition between the four-month placements. This changeover day is known as 'Grey Wednesdays'. Each new rotation involves joining a different department, working with a new team, managing unfamiliar patients, and adapting to different systems and ways of working. The changes can increase levels of anxiety amongst Foundation doctors. Uncertainties around the role can impact continuity of patient care on the ward.

No more Grey Wednesdays Scheme

The **No More Grey Wednesdays** scheme was introduced to minimise this disruption. This is an opportunity to seek support or shadow your fellow F1 in the job you are rotating into. Who better to give you a full account of the ins and outs of daily working life?

By giving you a chance to meet the team, understand your role and responsibilities, and just ask the questions that may be 'embarrassing' on the day. This scheme has proven to increase resident doctor confidence, benefit patient safety, and support the smooth running of hospital services.

Tips and Suggestions

- Shadowing scheme - some hospitals provide opportunities to shadow your Foundation peer in their specialty prior to changeover.
- Peer Orientation - dedicated time during teaching for Foundation Doctors to talk within their track groups and provide support.
- Handbook revision - use handbooks such as this or any local guides provided by your hospital to help support you before and throughout your new specialty.

Early planning is key! If you would like to participate in the scheme reach out to your rota coordinators in advance. Do not be afraid to reach out to Foundation reps for support.

Equality, Diversity and Inclusion

Dr. Rhema Otache

What is Equality, Diversity and Inclusion (EDI) in medicine?

Equality, Diversity and Inclusion (EDI) in healthcare refers to the actions and principles that ensure all staff and patients experience a safe, supportive and non-discriminatory environment. It recognises that individual differences strengthen the healthcare system and that equitable practice improves both workplace culture and patient outcomes (1).

Equality- Everyone should have access to the same opportunities, resources and treatment. **Equity** goes further by ensuring resources are allocated according to group needs.

Diversity- Recognising and valuing differences in background, identity, lived experience and perspective within both the workforce and patient population.

Inclusion- Going beyond representation to create an environment where differences are respected, understood and actively supported, and where systems actively work to meet the needs of all.

Why should EDI matter to you as a foundation doctor?

According to the 2023 GMC National Training Survey, over one third of foundation doctors reported experiencing discriminatory behaviours, including insults, stereotyping or jokes relating to protected characteristics. Despite this, many resident doctors did not feel comfortable speaking up (2).

Commonly cited barriers include **fear of career repercussions, hierarchical workplace structures, uncertainty about escalation pathways, and concern about not being taken seriously** (3).

With evidence suggesting foundation doctors may be at increased risk of experiencing discriminatory behaviours, it is essential that they are equipped with the knowledge, confidence and practical tools to recognise, challenge and appropriately escalate these issues.

What to do when encountering an EDI related issue in practice?

Experiencing or witnessing discrimination on the wards can be distressing, particularly as an FY1 navigating a new environment. However, addressing these behaviours is an important part of creating a safe, respectful workplace.

You are not expected to ignore discrimination, nor to manage it alone.

In the moment, the 5 “D”s of Active Bystander Intervention (Direct, Distract, Delegate, Delay and Document) offer practical options for responding in a way that feels safe and appropriate to you.

Equally important is knowing where and how to escalate concerns.

The next page expands on the 5 “D”s and outlines the support and escalation pathways available to you as a foundation doctor.

Equality, Diversity and Inclusion

Dr. Rhema Otache

Active Bystander Intervention- The 5 “D” s

Active Bystander Intervention is a practical framework that supports you to respond safely and effectively when you witness discrimination. It begins with noticing what is happening, recognising it is not acceptable, and deciding that you want to act. The 5 “D”s provide flexible options depending on the situation and your level of confidence (4):

Direct – Address the behaviour in the moment. This might involve calmly calling it out, setting a boundary, or redirecting the conversation.

Distract – Interrupt the situation without direct confrontation. For example, change the subject, ask an unrelated clinical question, or create a reason to move someone away.

Delegate – Seek support from someone else such as a senior colleague, educational supervisor, ward manager, or another trusted member of staff.

Delay – Check in with the person affected after the incident. Ask how they are and what support they would find helpful.

Document – Make a clear, factual record of what happened and store it safely in case it is needed later.

There is no single correct response. You may use one strategy or combine several. The priority is that your action is safe, proportionate, and centred on the needs of the person experiencing discrimination. Even small interventions can make a difference!

Where to escalate concerns?

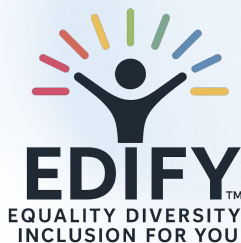
Where you escalate concerns depends on the incident and your level of comfort. In many cases, raising issues within your Trust is appropriate. However, Freedom to Speak Up Guardians are always available. They understand Trust processes while remaining independent and confidential and can advise you if you are unsure how to proceed.

It is also important to consider your own wellbeing. Raising concerns, particularly around sensitive issues, can be emotionally demanding. Ensure you make use of the support systems available to you and do not feel you have to manage these situations alone.

Within your trust	Outside the trust	Wellbeing Resources
1. Senior colleague on the ward	1. Freedom to speak up guardian- https://nationalguardian.org.uk/	1. Foundation administration team can signpost to local pastoral care
2. Clinical Supervisor	2. Foundation School Director	2. Speak to close colleagues/friends
3. Educational Supervisor	3. British Medical Association	3. British Medical Association wellbeing services
4. Department lead	4. General Medical Council	4. Text FRONTLINE to 85258 if experiencing mental health crisis
5. Foundation Programme Director	5. Police	
6. Medical Director		
7. Datix/Incident report		

References:

1. University of Bath. Equality, diversity and inclusion (EDI) [Available from: <https://www.bath.ac.uk/campaigns/equality-diversity-and-inclusion-edi-in-health-and-social-care-research-an-introduction/>]. 2. General Medical Council. National training survey 2023. 2023 July 2023 3. Tyson L, Skinner J, Hariharan B, Josiah B, Okongwu K, Semlyen J. Tackling discrimination in medicine head on: The impact of bystander intervention training. Medical Teacher. 2025;47(1):73–82. 4. Rebecca Cant. Brook [Internet]. [cited 2025]. Available from: <https://www.brook.org.uk/blog/how-to-be-an-active-bystander/>.



EDIFY

Dr. Rhema Otache

What is EDIFY?

EDIFY (Equality, Diversity and Inclusion For You) is a teaching programme developed and piloted in the North West, delivering interactive, scenario-based EDI training for Foundation Year One doctors.

It was created by Dr Dasha Ibrahim as part of her 2024/2025 UKFPO Fellowship, in response to a national survey of 753 foundation doctors. The survey found that only 7.8% felt they had received adequate equality, diversity and inclusion teaching, while over 90% expressed a desire for more education in this area.

EDIFY aims to raise awareness of the impact of EDI on workplace culture and patient outcomes. The programme explores key concepts such as privilege, bias, and power, encouraging reflection and open discussion. Crucially, EDIFY equips foundation doctors with practical tools and frameworks to recognise, address, and appropriately escalate issues of discrimination encountered in clinical practice.

How does EDIFY work?

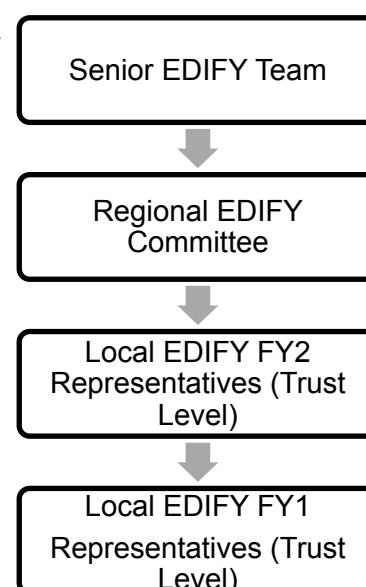
EDIFY is led by a senior team of doctors (F3 and above) who oversee the national rollout of the programme and are responsible for developing and updating teaching content.

The regional EDIFY committee coordinates delivery of the programme to FY1 doctors within the deanery and supports the recruitment and training of local representatives.

Within the North-West, each Trust has at least two FY EDIFY representatives who deliver teaching sessions locally. Delivery is primarily led by FY2 representatives, with FY1 representatives shadowing in preparation to lead sessions the following year. There are also opportunities to support delivery in neighbouring hospitals.

“Train the Trainer” sessions are held throughout the year to ensure representatives are fully prepared and supported in their roles.

Professional leave is provided to facilitate attendance at training and teaching sessions, ensuring involvement does not impact study leave allocation.



How can you get involved in EDIFY?

If you are interested in getting involved in delivering EDIFY teaching, please contact your local FY2 EDIFY representative, who can provide further information about upcoming sessions and opportunities.

For those interested in joining the EDIFY core committee and contributing to the national rollout and development of the programme, please submit an expression of interest to the email address below. Recruitment for new committee members takes place between August and December each academic year.

Contact EDIFY at: edify.teaching@outlook.com or edify.teaching@gmail.com

Options after FY2

Dr. Laura Okkels

Finished FY2, now what?

There are multiple routes you can go down, many doctors take a few years before entering training. Options include: specialty training, Academic Clinical Fellow (ACF), Junior Clinical Fellow (JCF), teaching fellow, locum work or working abroad. Each come with their own pros and cons summarised below.

Speciality Training

Applying for a UK training programme CT1/ST1.

Pros:

- Job security with stable income
- Structured progression
- Access to teaching, exams and portfolio support

Cons

- Competitive
- Less flexibility (years out, time off)
- Commitment to a career path early
- Exam and portfolio pressure

Tips

- Do tasters early in FY1/2 to confirm interest
- Start building portfolio early (audits, teaching, presentations)
- Have a backup plan!

Junior Clinical Fellowship (JCF)

A JCF is usually a 1-year non-training clinical post in one speciality.

Pros

- Gain experience in speciality before committing
- Time without exam/ portfolio stress
- Time to build on training applications

Cons

- No guaranteed teaching or progression
- Could feel like service provision

Tips

- Choose a JCF role in a speciality of interest
- Use this year to build your portfolio

Academic Clinical Fellowship (ACF)

Combined clinical job with protected academic time.

Pros

- Funded academic time
- Opportunities for portfolio growth e.g. presentations/ publications.

Cons

- Competitive
- Balancing clinical and academic work
- Less clinical time

Tips

- To improve your chances get involved in QIP/audits in FY1/2

Options after FY2

Dr. Laura Okkels

Working Abroad

Practicing medicine outside of the UK. Common countries include Australia, New Zealand, Canada, and more.

Pros

- Travel opportunities
- Experience different healthcare systems
- Can feel like a 'year out'
- Better work life balance in some countries
- Possibly higher pay

Cons

- Complicated and lengthy applications
- Relocation and visa costs
- Time out of training can affect training applications
- Becoming more competitive in some popular regions

Tips

- Registration can take months, start early
- Save up for Visas and relocation costs
- Consider timing if planning to return to UK for training starting in August/September

Teaching Fellow

A teaching fellow is usually a 1-year contract to teach medical students. Some offer solely teaching roles; others offer clinical days too.

Pros

- Break from on-call rota
- Good for portfolio
- Opportunities for PGCert in Medical Education

Cons

- Less clinical time

Tips

- Set up Teaching initiatives in FY1/2
- Keep a teaching portfolio with feedback

Locum

Working as a locum means picking up ad hoc shifts when there is a shortage of staff, usually at an enhanced rate.

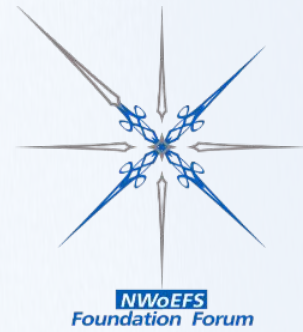
Pros

- Potential for high income
- Dictate your own schedule
- Exposure to different hospitals and specialties

Cons

- No continuity, may not know staff or IT systems
- May have to work more unsociable hours
- Lack of job security
- Locum market is becoming increasingly competitive

- Maintain portfolio for when you re-enter training
- Pick up shifts in busy periods, try and plan holidays in quiet periods
- Sign up to agencies
- More likely to get locum shifts in departments previously worked



Section 3



General Medicine

Dr. Maddie Slot

Introduction to General Medicine

On a general medicine ward, you will be exposed to a wide variety of medical conditions. Patients on these wards tend to be complex and multi-morbid, often with a combination of problems contributing to their hospital admission. Most hospitals have a general medicine ward that receives patients with general medical issues that do not require specialist management.

Many of them also have a background of frailty, alongside varied needs requiring a lot of input from other teams such as physiotherapy, occupational therapy, and social care/transfer of care teams.

Roles and Responsibilities as an FY1/2

Expectations of an FY1/2 across any general medicine ward include:

- Attending ward rounds and documenting clearly. After a while, you will likely be expected to perform daily reviews of stable or medically fit for discharge patients by yourself. Ward rounds will usually follow the same basic structure (history, targeted examination, checking of recent results + nursing charts such as bowel charts, plan), but you will be supported by seniors for this.
- Completing discharge letters + take home medications.
- Ordering, interpreting and actioning basic investigations.
- Communicating with other specialties.
- Updating patients + family members.

Important Knowledge / Skills

In general medicine, as patients can experience multiple issues, you often need to be coordinating with other specialties, either medical or surgical; it is your responsibility to chase these to ensure the patient gets the speciality input they need. Sensitive communication with family members + patients is vital, many patients admitted may need to have ceilings of care put in place; or have longer recovery times requiring extended admission or discharge to intermediate care facilities.

Common Conditions	Key Skills
It is hard to summarise the breadth of conditions seen due to the nature of general medicine, but the most common conditions include: • Infections: pneumonia, cellulitis, urinary tract infection, sepsis • Fluid overload • Delirium, causes of acute confusion • Electrolyte imbalances	• Procedural skills such as venepuncture, cannulation, and arterial blood gas sampling • Prescribing IV fluids and correcting electrolyte abnormalities • Communication with family members • Effective handovers to other specialties using an SBAR format • Interpretation of chest x-rays • End of life care – symptom management

Medical On-Call

Dr. Bethany Tabberer

Introduction to Medical On-Call shifts

Medical on-call shifts are to provide safe, ongoing care outside of normal hospital working hours. These include twilight, nights, weekends and bank holiday cover; essentially, for when full daytime clinical staff are not present on the wards.

As an FY1 Doctor, you will usually be expected to carry a bleep and work within a team consisting of house officers, on-call registrars and supporting ACPs and night practitioners. Your role is not to perform the normal ward work, as medical team numbers are much less out-of-hours. The purpose of the on-call shift is to recognize and address any acute illness or urgent task and respond to the deteriorating patient.

Tips for responding to the bleep: Before receiving any details of a handover over the phone, always make sure you take note of three identifiers to help you look at the patient record later:

1. Ward number
2. Patient's full name
3. NHS/hospital number

It is useful to also get the patient's date of birth. Often when you're bleeping back to a ward, the nursing staff may request for several patients, and it is easy to get lost in the detail, making it difficult to recall exactly which patient if you do not have these items to hand. Make sure you dispose of any paper notes with these details in the confidential waste bin at the end of your shift/when no longer required.

Roles and Responsibilities as an FY1/2

Expectations of a FY1/2 across all medical on-calls include:

- Attending handovers; reporting ill patients
- Responding to ward bleeps
- Order, review and interpret investigations/scans
- Responding to peri-arrest/cardiac arrest calls
- Post-falls review; requesting appropriate investigations (e.g. CT head, pelvic x-ray)
- Escalation of deterioration to senior house officer/medical registrar
- Death verification
- Documentation
- Liaising with off-site specialties

You may be attending areas of the hospital that you will never experience as a rotation. It is important to follow-up, or put provisions in place, so that things don't get missed. A good example would be; at Macclesfield District General Hospital, there is no on-site urology department. If an out-of-hours job includes making a referral to urology, you should copy members of the regular ward staff (identified from the documentation) into the referral, so that things are not missed to follow-up. In addition, in an ad hoc note on the medical record, I would state the on-call request, any actions taken and those outstanding, and the contact details of how to follow-up with any reference information. This makes things easier for the regular ward doctors to chase upon return.

Medical On-Call

Dr. Bethany Tabberer

Important Knowledge / Skills to Read About

Medical on-calls often have limited medical staff in the hospital, so it is important that you act independently and confidently. Equally, it is important to recognise when something is above your level of experience or competency, and communicate with senior clinicians if escalation is required. Key skills to focus on include:

- Checking daily INR results; Warfarin dosing
- A – E assessment in a scoring patient
- Fluids prescribing
- Correcting electrolyte imbalances
- Catheters
- Cannulas, venepuncture
- Chase blood results
- Follow trust guidelines for new presentations
- Clinical assessment
- Escalation of requests (e.g. vetting scans with on-call radiologist for urgent CT head)
- VTE prophylaxis
- Requesting Group and Save, ordering blood units if transfusion is indicated

Common Conditions	Key Skills
Acute Kidney Injury (AKI) Chest pain: acute coronary syndrome, myocardial infarction, musculoskeletal Confusion/delirium: urinary tract infection, chest infection, hypoglycaemia Constipation CVA/TIA Diabetic emergencies: hypo-/hyperglycaemia, hyperosmolar hyperglycaemic state, diabetic ketoacidosis Electrolyte imbalances: hyponatraemia, hyperkalaemia Gastrointestinal bleed: haematemesis, coffee-ground vomit, haematochezia, melaena Nausea/vomiting Peri-arrest/cardiac arrest: requires A – E assessment, Intermediate Life Support and Advanced Life Support, if trained/to be directed by qualified clinicians Sepsis Tachypnoea: COPD/asthma exacerbation, pulmonary embolism, pneumonia, pulmonary oedema	Blood gas interpretation (arterial/venous) ECG (ensure senior review) Follow trust guidelines (e.g. choice of antibiotics for pneumonia may differ between geographical locations) Recognize sick vs. non-sick patients; prioritize jobs accordingly Analgesia prescribing (WHO pain ladder) Clinical assessments

General Surgery

Dr. Caitlin Ryder

Introduction to General Surgery

General surgery in the North West is delivered through a network of major tertiary centres supported by district general hospitals. Surgical services cover a broad range of emergency and elective procedures, including upper and lower GI, hepatopancreatobiliary (HPB), colorectal, breast, endocrine, and trauma surgery. The region serves a large and diverse population, with high volumes of colorectal cancer, hepatobiliary disease, and emergency surgical cases.

Tertiary and specialist general surgery centres within the North West of England:

1. Manchester Royal Infirmary – home to specialist HPB and upper GI services with close links to ICU and interventional radiology (IR).
2. Royal Liverpool University hospital – major tertiary centre for colorectal surgery, oncology and emergency surgery, including the regional oesophago-gastric cancer hub.
3. Salford Royal Hospital – nationally recognised intestinal failure unit, providing specialist management of complex intestinal failure and parenteral nutrition.

Roles and Responsibilities as an FY1/2

Expectations of a FY1/2 across all general surgical units

- Follow ward rounds and documenting clearly
- Recognise unwell patients and post-operative complications, starting initial management and escalating early
- Order, chase and interpret investigations
- Monitor fluid charts including stoma and drain output
- Prepare patients for theatre and provide post-operative care, such as VTE prophylaxis, analgesia, and antiemetics
- Complete discharge summaries in a timely manner and update family members

Important Knowledge / Skills to Read About

- Working closely with other members of the MDT including specialist nurses, dieticians and nutritionists, radiology and IR, speech and language teams, and gastroenterologists.
- Develop clinical skills including scrubbing in and assisting in theatre, suturing and wound closure, and laparoscopic camera techniques.
- Support nutrition and feeding discussions including early recognition of malnutrition and decisions regarding the route of feeding.

General Surgery

Dr. Caitlin Ryder

Common Conditions	Key Skills
Upper GI surgery: hiatus hernia, oesophageal malignancy, cholecystitis, morbid obesity Lower GI/colorectal surgery: colorectal cancer, diverticular disease, colitis, appendicitis Hepatobiliary: cholecystitis, cholangitis, malignancy, hepatic trauma Pancreatic surgery: acute and chronic pancreatitis and associated complications, malignancy Trauma and emergency surgery: bowel obstruction, strangulated/incarcerated hernia, perforated viscus, surgical site infections, anastomotic leak	• Venepuncture, cannulation, US-guided access, catheterisation, NG tube insertion and ABGs. • Managing fluid balance in pre- and post-operative patients including monitoring drains. • A-E assessments and prepare patients for emergency theatre. • Recognise the most common post-operative complications including wound dehiscence, infection, anastomotic leak, ileus etc. • Support patients' post-operative recovery including pain management, wound care, and mobilisation.

Surgical On-calls

Dr. Raveen Sagoo

Introduction to surgical on-call shifts

Most foundation doctors will have at least one surgical rotation during foundation training or be dealing with surgical patients in a wider setting, in this placement you will be expected to perform ward duties, clerk patients and be able to recognise unwell patients. On call shifts can occur during evenings, nights, or weekends, when staffing levels can be lower and decision-making must be efficient and prioritised.

Specialties that you might be covering include hepatobiliary and pancreatic, urology, colorectal, upper gastrointestinal and sometimes cross cover with orthopaedic, vascular or ENT– this varies in each trust and it should be highlighted in your induction, as well as letting you know who to escalate to.

Foundation doctors should be familiar with common surgical presentations such as abdominal pain, bowel obstruction, appendicitis, sepsis, and more specific post-operative complications to your speciality. They are a great opportunity to practice procedural skills and become familiar with equipment.

Roles and Responsibilities as an FY1/2

Expectations of a FY1/2 across all surgical specialties include:

- Attending ward rounds and documenting clearly
- Initial reviews of unwell patients and escalating appropriately - know your team members
- Order, chase and interpret basic investigations/scans
- Prepare patients for theatre and be aware of the consenting process (you should not be consenting patients for surgery unless you are capable of performing that particular surgery)
- Complete discharge summaries and inform their healthcare providers of changes
- Communicate with family members about care and decisions
- Answer bleeps and prioritise your patients
- Assisting in theatre – be aware of the procedure beforehand, you might be holding a retractor, suctioning or cutting sutures

Important Knowledge / Skills to read up on

On-calls are a great opportunity to gain hands-on experience with surgical skills. With many of these tasks, it is best to observe once, then do it the first time with a senior supporting you.

These can often count as DOPS (direct observation of procedural skills) on Horus:

- Removing drains
- Incision and drainage
- Suturing
- Removal of foreign bodies
- Manipulations/adjustments
- Nasogastric/flatulence tube

Surgical On-calls

Dr. Raveen Sagoo

Common Conditions	Key Skills
POST OP: anastomotic leak, wound dehiscence, ileus, bowel obstruction SEPSIS: wound infection, hospital acquired pneumonia, missed injury, abscess HAEMORRHAGE: surgical site bleed, excess anti-coagulants or anticoagulation not reversed TRAUMA: must do a top to toe examination even if the patient is showing you the main injury PAIN: work up the pain ladder and check if they have any regular analgesia in the community FLUID BALANCE: acute kidney injury (injury related blood loss or intra-operatively), poor nutrition or bowels dysfunction, catheter NAUSEA & VOMITING: very common either as a presentation or post op complication	Full A-E examination - treating and resuscitating as you go along Recognise red flags e.g. post op tachycardia or pale pyrexia patient Interpret basic scans e.g. abdomen Xray/ CT with contrast Recognition of when a wound is not healing or a patient isn't progressing Manage fluid and electrolytes (especially sodium)

Emergency Medicine

Dr. Christopher Davies

Introduction to Emergency Medicine

Emergency medicine will challenge you with a wide range of problems to solve. Of course it's busy, of course it's often full – but which emergency departments (EDs) aren't?

The Major Trauma Centres in the North West include: Manchester Royal Infirmary, Salford Royal (which houses the Greater Manchester Major Trauma Hospital), Aintree University Hospital, and Royal Preston Hospital. The Paediatric Major Trauma Centre in the North West is Alder Hey Children's Hospital.

The ED is the route via which the vast majority of patients are admitted to hospital. The decisions and actions made here can set the course for the patient's hospital journey.

Roles and Responsibilities as an FY1/FY2

Expectations of an FY1/2 working in the Emergency Department include:

- Seeing a wide range of patients in a range of different areas with different levels of acuity (resus, majors, minors, paediatric ED) and coming up with a differential diagnosis
- Requesting the appropriate investigations/imaging to help guide your diagnosis
- Referring patients to the appropriate specialty/service once you are confident in a diagnosis
- Coming up with a timely plan and keeping the rest of the team in the loop
- Escalating unwell patients appropriately, in a timely manner – initial stabilisation/imaging is often done by the ED but prompt involvement of the relevant specialty is paramount
- Treatment of patients in the ED for those conditions which don't need admission (e.g. home with antibiotics for pneumonia, wound closure, joint relocation etc.)
- Discuss with a senior if you are unsure how to proceed!

Important Knowledge / Skills

You will have the opportunity to learn/practice lots of skills which you can take with you into the rest of your clinical practice, for example: US guided procedures (e.g. cannulation), point of care ultrasound (for aortic aneurysm, in trauma etc.), joint reduction and more!

It's important to get to know the referral pathways for certain conditions/presentations (what things go to which specialty), which will save you time and hassle.

Emergency Medicine

Dr. Christopher Davies

Common Conditions (realistically, anything)	Key Skills
Resus: sepsis (haemodynamically unstable), diabetic ketoacidosis, polytrauma, joints that need reduction under sedation, life-threatening/near fatal asthma/COPD, acute coronary syndrome with concerning features/high risk of arrhythmia/deterioration. Anyone who is seriously unstable will be transferred here. Majors: acute coronary syndrome, asthma/COPD exacerbation, sepsis, frail patients with falls, renal/biliary colic, cholecystitis, pyelonephritis, urinary retention, gastroenteritis. Can be extremely varied here Minors: mainly isolated joint/extremity trauma Paediatrics: asthma/viral wheeze, bronchiolitis, croup, gastroenteritis	Focused histories/examinations broadly covering most systems and covering the relevant systems in more depth. Keep the patients on topic so you don't waste time. Make sure to document all important negatives found on examination. Handover: When referring, this should be concise but carry all of the important info. You want your patient to get accepted, but you want to get the info across efficiently. Handing over unfinished patients to colleagues must be done effectively to ensure continuity of care. Imaging/investigation interpretation: Often, having objective investigation results or imaging findings can help you to sell a referral or reassure yourself when discharging. Clear documentation: You must ensure that any accepting referrer knows the full story, what was present AND what was absent/excluded. This is equally as important if you are discharging someone as you need to have excluded serious pathology.

General Practice

Dr. Jessica Man

Introduction to General Practice (GP)

- This rotation is a great way to familiarise yourself with common presentations in primary care and an insight into the workload and the life of a GP
- All foundation doctors in the North West will have a GP placement during their FY2 year
- Your trust will allocate your GP practice to you ahead of your rotation starting, and some trusts use your residential address to allocate you to GP practice that is at a reasonable distance from your home

Roles & Responsibilities as an FY2

- You will be running your own GP clinics in the mornings and afternoons independently, seeing a variety of patients face-to-face or over the telephone.
- The appointment time slot is initially 30 minutes per patient – when you feel more confident, your GP supervisor may reduce the appointment slots to 20 minutes
- You will be assigned a GP supervisor who will directly/indirectly supervise your clinics, e.g. after seeing a patient on your own, you can relay the history and assessment findings to your supervisor to help form a sensible management plan.
- Management plans often include strong safety netting advice, prescribing medications using paper or electronic FP10 forms, requesting bloods/scans, referral to specialists, 2 week wait referrals, and subsequent follow-up appointments.
- A separate time slot, during the day, will be allocated for you to review the blood tests, scans, and referrals requested and for you to formulate a plan based on the result of the investigations, such as calling the patients to update them.

Important Knowledge and Skills & GP Resources

Helpful resources to use include:

- Greater Manchester Medicines Management Group – for antibiotics guidance
- GP Resources – for patient information leaflets (PILs)
- GP Notebook – for summarised guidelines
- Primary Care Dermatology Society – for dermatology guidance (includes images for different skin colours and online/printable PILs)
- Macmillan Cancer Support – rapid referral guidelines for suspected cancer
- NICE CKS & BNF- for national guidelines and prescribing information

Common Conditions	Key Skills
• Rashes, e.g. eczema, scabies, fungal infections • Mental health, e.g. depression, anxiety • Coughs and colds in the winter months • Paediatrics, e.g. wheeze, cough, abdominal pains • Gynaecology, e.g. PCOS, endometriosis • ENT, e.g. hearing loss, balance issues • MSK, e.g. lower back pain, joint pains • Feeling tired all the time • Headaches • Medication reviews • Pain management for long-term conditions	• Time keeping and prioritisation skills to prevent overrunning your clinic slots • History taking and various examination skills (e.g. otoscopy, speculum examination, paediatric examination etc.) • Recognising red flags symptoms for 2 week wait referrals, e.g. visible haematuria • Writing GP referral letters and advice and guidance letters • Assessing undifferentiated complaints • Providing continuity of care for patients with long-term conditions

Acute Internal Medicine

Dr. Kai Harrington

Introduction to Acute Internal Medicine

Most hospitals have an acute internal medicine unit. The name of this unit may vary between hospitals, e.g. acute medical unit (AMU), medical assessment unit (MAU), emergency assessment unit (EAU), etc. The AMU receives patients that require inpatient assessment and treatment under a medical team. Patients are usually referred from A&E or GP, and most units tend to be directly connected to A&E. Some patients from A&E or GP will be more suitable for same day emergency care (SDEC), a service within acute medicine which helps avoid hospital admission – for example, patients with suspected DVT or some acute headache presentations. Patients tend to stay on AMU for approximately 24-72 hours before they are either discharged home if well enough or referred to the appropriate medical specialty for specialist care.

AMU is a great rotation for learning! On a typical day, you will either be clerking new medical patients from A&E or reviewing current inpatients on the ward round. Similar to A&E, you will encounter a great breadth of medical conditions on AMU, and these units often have senior support readily available due to the acute nature of the role.

Roles and Responsibilities as an FY1/2

- Clerking new medical admissions from A&E: performing a history/examination, ordering initial investigations, formulating and actioning an initial management plan, and prescribing regular medications and VTE prophylaxis as appropriate
- Escalating unwell patients to your senior(s) early, particularly when clerking
- Documenting ward rounds clearly
- Liaising and working with a breadth of medical specialties and MDT members including specialist nurses, PT/OT, etc
- Ordering and chasing investigations such as x-rays, CT or MR scans, echocardiograms etc
- Completing discharge summaries/TTOs
- Updating relatives about unwell patients, and approaching discussions about end of life/prognosis

Important Knowledge / Skills

- Many procedures are performed in AMU, such as US-guided procedures, lumbar punctures and ascitic drains – you should expose yourself to these and aim to learn and practice them where possible!
- A rotation in AMU is a great opportunity to bulk out your portfolio, as you are exposed to a breadth of conditions and skills and you tend to work with a large team – request CBDs for cases where you seek advice and have discussions with seniors, request mini-CEXs for SBAR handovers or if you are observed clerking/consulting, and ensure to get procedural opportunities signed off as DOPS

Acute Internal Medicine

Dr. Kai Harrington

Most Common Conditions / Presentations	Key Skills
Cardiology: acute coronary syndrome, atypical chest pain, decompensated heart failure, atrial fibrillation, atrial flutter and other SVTs, other arrhythmias including those due to drugs and electrolyte disturbances, hypertensive emergency Respiratory: pneumonia, influenza, exacerbation of COPD/asthma, PE, type 2 respiratory failure Gastroenterology: upper GI bleed, gastroenteritis, decompensated liver cirrhosis (e.g. ascites, hepatic encephalopathy), flare of inflammatory bowel disease, functional abdominal pain Neurology: acute severe headaches such as meningitis and encephalitis, seizure, stroke, functional neurological disorder Other: AKI, acute on chronic kidney disease, sepsis, UTI, cellulitis, DVT, diabetic ketoacidosis, causes of severe diarrhoea/vomiting, delirium, falls and reduced mobility, causes of acute back pain, drug overdose, alcohol and substance misuse, new malignancy diagnosis	• Clerking patients: history -> examination -> investigations and initial management -> ?escalate/advice from senior • Referring to other specialties • Interpreting ECGs, X-rays and blood gas results, and applying the indications for NIV • Utilising trust policies for the most common medical presentations/conditions, e.g. ACS, pneumonia, diabetic ketoacidosis • Escalating for senior support early • Discussing antibiotic decisions with microbiology • Giving and receiving an SBAR handover of unwell patients / patients with outstanding jobs that need completing or chasing • Ensuring resuscitation status has been considered for all new admissions (you can politely remind your seniors if a CPR status has not been determined)

Cardiology

Dr. Abdul Mannan Tariq

Introduction to Cardiology

Cardiology services are widespread throughout the Northwest. Services are provided by DGHs as well as tertiary centres. Smaller DGHs can treat patients presenting with acute coronary syndrome (ACS), arrhythmias, heart failures and provide inpatient telemetry monitoring. Some DGHs such as Blackburn and Bury provide percutaneous coronary intervention (PCI) services such as angiography and stenting. However, this tends to be during working hours. More complex cases that require cardiothoracic input such triple vessels disease or valve replacement are referred to tertiary centres. These centres also have 24/7 cath lab operation.

Major tertiary centres include:

- Blackpool Victoria Hospital
- Liverpool Heart and Chest Hospital
- Manchester Royal Infirmary

Roles and Responsibilities as an FY1/2

- Attending ward round, clearly documenting, and prescribing medications.
- Requesting important scans including work up for a coronary artery bypass graft or valve replacement surgery. e.g. Echo, Pulmonary function tests (PFTs), USS carotid doppler, CT coronary angiography (CTCA)
- Reviewing unwell patients on the ward and escalating appropriately.
- Completing TTOs and discharge letters
- Opportunities to attend the cath lab to see PCI ± stent insertions, pacemaker insertions, clinics

Important Knowledge / Skills

- Interpretation of ECGs recognising pathology e.g. STEMI, NSTEMI, atrial fibrillation (AF), supraventricular tachycardia (SVT), ventricular tachycardia/fibrillation, heart blocks.
- Becoming familiar with common drugs e.g. diuretics, dual antiplatelet therapy, rate and rhythm control. Knowing common side effects of these medications and how to treat them.
- Assessing and managing patients with chest pain: cardiac and non cardiac causes.
- Knowing what investigations to order: ECGs, bloods - troponins, NT-pro BNP.

Cardiology

Dr. Abdul Mannan Tariq

Common Conditions	Key Skills
ACS: STEMI, NSTEMI, unstable angina Heart failure: heart failure with preserved ejection fraction (HFpEF) and heart failure with reduced ejection fraction (HFrEF), decompensated heart failure, cardio-renal syndrome Tachyarrhythmias: Narrow complex such as atrial fibrillation, flutter and SVT. Broad complex such as ventricular tachycardia/fibrillation Bradyarrhythmias: 1st 2nd and 3rd degree heart blocks. Indications for pacemaker insertion	Able to take a thorough cardiac history and examination. Common presentations include chest pain, shortness of breath, syncope Confident in interpreting ECGs Familiar with the initial treatment of ACS and HF. Sound knowledge of commonly used medications and their intended effect Recognising side effects of medications e.g. diuretics causing electrolyte abnormalities - usually low Na⁺ and K⁺, dry cough with ramipril, peripheral oedema with amlodipine

Respiratory Medicine

Dr. Thevaguru Swarnaprabha

Introduction to Respiratory Medicine

Respiratory medicine in the North West is delivered through an integrated care system model, where different levels of healthcare work together to deliver care. In practice this means that, as an F1/F2 at a district general or specialist hospital, care is delivered by liaising with both local primary centres or advanced tertiary centres.

A few examples of respiratory care on the local level are:

- Respiratory specialist nurses who focus on asthma, COPD and long-term oxygen therapy
- Smoking cessation services
- Pulmonary rehabilitation
- Virtual respiratory wards

The main tertiary centre for respiratory medicine is Wythenshawe's North West Ventilation Unit. They provide:

- Lung transplant/surgery assessments
- The National Aspergillosis Centre
- Complex lung diagnostics
- Liaison for more complex patients

Roles and Responsibilities as an FY1/2

- Contribute to daily ward rounds including board rounds, preparing notes, documentations, and completing jobs generated
- Assist in patient flow with discharge letters and prescriptions
- Assess acutely unwell patients & escalate early
- Liaise with the wider MDT and specialties
- Update NOK and DNACPAR/ceilings of care discussions
- Check appropriate steroid prescriptions & weaning regimes (NB each consultant has a different preference for weaning so be sure to ask)
- Titrate oxygen levels
- Ensure aminophylline levels are taken for patients taking this medication
- Check daily weights and U&Es for patients on furosemide

If you are keen there is the opportunity to take part in respiratory clinics, bronchoscopy, lung cancer MDTs, and pleural procedures including drains, taps/aspirations, and talc pleurodesis.

Important Knowledge / Skills

Respiratory medicine is an excellent rotation for familiarly with situations you will encounter acutely during on-calls and in the community in primary care:

Respiratory Medicine

Dr. Thevaguru Swarnaprabha

Common Conditions	Key Skills
Airflow: COPD, Asthma, bronchiectasis Infective: pneumonia, COVID, TB, flu Malignancies: lung cancer, mesothelioma Pleural: effusion, pneumothorax, empyema Mechanical: obstructive sleep apnoea, obesity-related hypoventilation syndrome Inflammatory: interstitial lung disease, sarcoidosis Genetic: cystic fibrosis, neuromuscular disease	CXR interpretation (e.g. effusions, pneumonias, chest drains) Interpretation of capillary blood glucose results, especially for patients on non-invasive ventilation Understanding respiratory pharmacology including steroid regimes, antibiotics and inhalers/nebulisers Recognising clinical signs on auscultation of the chest Considering baseline need for oxygen/nebulisers when assessing fitness for discharge

Gastroenterology

Dr. Mia Townson-Crompton

Introduction to Gastroenterology

Gastroenterology in the North-West of England is delivered at different levels depending on the needs of the patient. From specialist care in tertiary hospitals to local gastroenterology services in district general hospitals.

While not all hospitals have dedicated gastroenterology wards, gastroenterological conditions feature heavily in everyday medicine. These patients have the potential to deteriorate rapidly and sometimes unpredictably. This makes thorough documentation, forward planning, early assessment and senior escalation vital for patient safety.

Roles and Responsibilities as an FY1/2

- Attending ward rounds and preparing discharge summaries
- Reviewing unwell patients early and escalating appropriately
- Ensuring basic investigations are ordered and reviewed/acted upon promptly
- Reviewing regular medications daily, including converting oral to enteral/IV
- Working closely with specialist nurses, dietitians, physiotherapists...
- Ensuring family members and patients are well updated with results/plans

Important Knowledge to Read About

- Total parenteral nutrition (indications, refeeding bloods, routes, electrolyte criteria, complications)
- British Society of Gastroenterology guidelines
- Ascitic taps and drains
- Endoscopy/colonoscopy (diagnostic and therapeutic)
- British Association for Study of the Liver bundle (24-hour checklist for decompensated liver disease)
- Types of feeding tubes eg. NG, NJ, PEG, JEJ
- Specialist tests/scores eg. faecal calprotectin, biologic screen, Glasgow-Blatchford Bleeding Score, Clinical Institute Withdrawal Assessment for Alcohol score and Malnutrition Universal Screening Tool score

Common Conditions	Key Skills
• Hepatology: cirrhosis, alcohol related liver disease, hepatitis (viral, alcoholic, autoimmune), spontaneous bacterial peritonitis (SBP), hepatic encephalopathy, Wernicke's encephalopathy, alcohol withdrawal, metabolic dysfunction-associated steatotic liver disease (MASLD) • Malnutrition: avoidant/restrictive food intake disorder, refeeding syndrome, eating disorders, gastric bypass/sleeve complications, malabsorption • Gastrointestinal: upper GI bleeds (peptic ulcers, varices), inflammatory bowel disease (Crohn's and Ulcerative Colitis), chronic pancreatitis, gastritis, gastroparesis, chronic diarrhoea • Oncological: pancreatic/gastric cancer, hepatocellular carcinoma	• Capacity assessments, abdominal examinations, basic A-E assessments • Recognising red flags e.g. melaena, confusion • Interpret basic scans/tests e.g. LFTs, stool tests, OGD reports, AXR • Preparing patients for scope procedures • Basic principles of management of specific conditions eg. hepatic encephalopathy > lactulose and rifaximin • Managing patients with poor/no oral intake • Emergency management of upper gastrointestinal bleeds, sepsis and decompensated cirrhosis

Renal Medicine

Dr. Florence Evans

Introduction to Renal Medicine

Adult nephrology services in the North West are managed by the North West Kidney Network, which operates with a system of hub units, each attached to various satellites. The more complex inpatients from the satellite centres are often transferred to the hubs. The hubs are:

- Arrowe Park Hospital
- Royal Liverpool University Hospital
- Aintree University Hospital
- Alder Hey Hospital
- Manchester Royal Infirmary
- Salford Royal Hospital
- Royal Preston Hospital

Roles and Responsibilities as an FY1/2

- Attend and document ward rounds, specifically focusing on fluid status and input/output charts
- Carry out fluid balance assessments
- Review deteriorating patients and escalate to seniors if necessary
- Order and chase investigations and liaise with other specialties for input
- Venepuncture and cannulation on patients with difficult access
- Occasionally write dialysis scripts with guidance from seniors
- Can learn about tunnelled/temporary dialysis line insertion
- Update families and patients

Important Knowledge / Skills

- Important to recap the main causes of AKI and CKD.
- Large burden of diabetic patients – it's essential to know how to manage diabetic emergencies and complications of diabetes e.g. diabetic foot disease.
- Sensitive communication with patients and family is essential as patients are often very ill and can die at young ages.
- Good venepuncture and cannulation skills are needed e.g. with ultrasound as patients often have poor IV access (but this is easily learnt on the job).

Common Conditions	Key Skills
• AKI requiring haemodialysis or not improving • CKD patients who are either already established on renal replacement therapy (RRT) and have a complication (e.g. line infection/peritonitis from peritoneal dialysis), or those who have acute deterioration of renal function requiring initiation of RRT • Renal transplant complications e.g. infection or failure of the graft • <i>Complex/well-known renal patients who are admitted for non-renal reasons e.g. CAP or gastroenteritis are often also admitted to renal wards</i>	• Basic clinical skills e.g. venepuncture and cannulation, with the opportunity to learn US guided cannulation • Communication skills with patients and families • Examination skills – signs of fluid overload • Management of insulin-dependent diabetes  NW Kidney Network

Neurology

Dr. Rita Mathew

Introduction to Neurology

Neurology in the North West of England is delivered through a network of large tertiary centres that receive referrals from district general hospitals and clinics running across the region. Neurology covers a vast array of conditions and diseases that can present in unique and varied manners, often requiring specialist input and testing.

There are three major neurology centers in the North West of England:

1. Manchester Centre for Clinical Neurosciences (Salford Royal Hospital)
2. Royal Preston Hospital (Lancashire Teaching Hospital)
3. The Walton Center (Liverpool)

Roles and Responsibilities as an FY1/2

Expectations of an FY1/2 across neurology units include:

- Attend ward rounds, documenting clearly, reviewing VTE prophylaxis, and addressing patients' resuscitation status
- Initial reviews of unwell patients and escalating appropriately
- Order and chase investigations/scans such as EEGs, EMGs, CT/MRI/PET scans, and nerve biopsies
- Clerk in elective admissions for video telemetry, levodopa challenges, PEG insertions, etc.
- Complete discharge summaries/TTOs and updating family members

Important Knowledge / Skills

Neurology specific tasks:

- A great opportunity to become familiar with lumbar punctures and eventually start performing them independently if you are keen to do so, as they take place relatively frequently on a neurology unit.
- Becoming familiar with certain autoimmune screening panels, paraneoplastic panels, and pre-biologic panels as these often comprise a patient's initial work up.
- Referral and consent process for PLEX (plasma exchange) as this is done in collaboration with the renal unit.

Common Conditions	Key Skills
Sudden onset conditions: acquired brain injury or spinal cord injury Intermittent and unpredictable conditions: epilepsy, headache, or the early stages of multiple sclerosis Progressive conditions: motor neurone disease, Parkinson's disease, or later stages of multiple sclerosis Stable neurological conditions: post-polio syndrome, or cerebral palsy in adults Functional Neurological Disorder	• Full neurological examination (GCS, cranial nerves, upper/lower limb) • Interpret basic scans e.g. CT head/ MRI spine • Recognition of UMN/LMN signs • Seizure recognition – differentiating between epileptic seizures and NEADs • Seizure management including status epilepticus

Stroke Medicine

Dr. Ellie Rigby

Introduction to Stroke Medicine

Stroke medicine within the North West of England is managed across a number of hyper acute/acute stroke centres and district general hospitals (DGH).

All suspected strokes should be discussed with the local hyper acute/acute stroke centre to consider transferring patients for management. This may involve thrombolysis/thrombectomy. Once out of the acute phase, patients are often stepped down to their local DGH for ongoing management and rehabilitation. Alternatively, on initial discussion with the hyper acute/acute stroke centre, they may decide that the patient is for local management e.g. if they are unsuitable/out of the time window for thrombolysis/thrombectomy. Local management generally involves management and rehabilitation at a DGH.

Hyper acute/acute stroke centres in the North West include:

- Greater Manchester & Eastern Cheshire: Salford Royal Hospital, Stepping Hill Hospital, Fairfield General Hospital.
- Lancashire & South Cumbria: Royal Preston Hospital, Royal Blackburn Hospital, Blackpool Victoria Hospital, Royal Lancaster Infirmary.
- Merseyside & North Cheshire: Aintree University Hospital, Whiston Hospital, Arrowe Park Hospital.

Roles and Responsibilities as an FY1/2

- Attending ward rounds with seniors or independently, documenting and completing jobs that have been identified during the ward round.
- Reviewing deteriorating patients, starting initial management and escalating to seniors as required.
- Completing jobs e.g. prescribing medications, requesting and reviewing bloods, scans and other investigations.
- Completing discharge prescriptions and discharge summaries.
- Communicating with patients and their relatives with a key focus on managing expectations.
- Attending meetings with the wider MDT.

Important Knowledge / Skills

- Different locations of strokes and how they present.
- Thrombotic vs haemorrhagic strokes and how management of these differs.
- Management of patients with dysphagia e.g. insertion and management of a patient with an NG/PEG tube.

Stroke Medicine

Dr. Ellie Rigby

Common Conditions	Key Skills
• Thrombotic stroke • Haemorrhagic stroke • Recurrent stroke • Haemorrhagic transformation of a stroke • Dysphasia • Dysphagia • Aspiration pneumonia • Upper GI bleed secondary to anticoagulation • Refeeding syndrome • Post stroke anxiety and depression • Catheter-associated UTI • Falls • Cognitive impairment • Spasticity and contractures • Mobility issues • Post stroke fatigue	• NG tube placement • Neurological examination • Chest XR interpretation including assessing the placement of an NG tube • Working closely with the wider MDT (e.g. PT, OT, SALT, orthoptists, dieticians, nurses) • Mental health reviews • Management of diabetes with altered diet post stroke • Recognition of neurological decline • Organising post stroke work up (may include ECG, 24 hour tape, ECHO, US Doppler carotid arteries, bloods including lipid profile) • Blood pressure management • Liaising with regional stroke centres • Secondary prevention prescribing

Geriatrics

Dr. Ishan Jain

Introduction to Geriatrics

Geriatrics focuses on the care of older adults with frailty, multimorbidity, cognitive impairment, and complex social needs. Largely, this takes place on inpatient wards, however there is increasing demand for short stay units such as Stepping Hill Hospital in Stockport and Warrington Hospital, as well as outpatient frailty clinics.

Geriatrics is one of the most holistic and educational foundation placements. It offers regular exposure to comprehensive medical and social assessments, complex and ethical decision-making surrounding end of life care, and multidisciplinary team working.

Roles and Responsibilities as an FY1/2

Expectations of an FY1/2 across all geriatrics placements:

- Clear documentation during ward rounds, family discussions, and multidisciplinary team meetings
- Ordering, chasing and interpreting investigation results
- Discussion with other specialties and members of the multidisciplinary team
- Completing timely discharge summaries
- Assess, examine and appropriately escalate acutely deteriorating patients
- Verification of death and referrals to the Medical Examiner

Important Knowledge / Skills

During a geriatrics rotation, it is possible to see patients from every specialty, both medical and surgical, due to some of the patients' complexities. Foundation doctors will commonly encounter clinical, social and ethical issues.

Common Conditions	Key Skills
Dementia: Alzheimer's, vascular, Lewy Body, frontotemporal Delirium: hyperactive, hypoactive, mixed Infections: urinary tract, respiratory, skin (especially pressure ulcers) Frailty: falls, postural hypotension, polypharmacy, urinary and faecal incontinence Gastrointestinal: constipation, <i>Clostridium difficile</i> infection Bone: osteoporosis, fractures (commonly hip) Cardiovascular: heart failure, atrial fibrillation Neurological: stroke, Parkinson's disease Psychological: depression, psychosis Other: COPD, diabetes, chronic kidney disease, cancers	• Mental Capacity Assessment • A-E assessment of acutely unwell older adult • Cardiovascular, respiratory, abdominal and neurological examinations • Falls assessment • Fluid status assessment and management • Rapid tranquilisation • Management of polypharmacy • End of life care • Verification of death

Haematology

Dr. Georgia Hagger

Introduction to Haematology

Haematology services in the North West of England are delivered through a network of centres that offer specialist care and advice. Patients are often initially assessed in district general hospitals and may be referred to tertiary haematology units for further investigation or specialist treatment. Haematology patients can deteriorate rapidly, particularly in the context of conditions such as neutropenic sepsis, leukaemias, or haemolytic conditions. Early recognition and prompt escalation of these conditions is essential to ensure safe and effective care.

The main haematology centres for more complex diagnosis and management of haematological conditions in the North West include:

- The Christie NHS Foundation Trust
- Manchester Royal Infirmary
- Royal Liverpool University Hospital
- Blackpool Victoria Hospital
- Royal Preston Hospital

Roles and Responsibilities as an FY1/2

Expectations of F1/F2 doctors working in Haematology centres vary upon the centre, but can include

- Attending and documenting ward rounds
- Reviews of unwell patients eg suspected neutropenic sepsis, and escalating these
- Ordering, chasing and interpreting investigations such as FBC/ blood films/ coagulation screens
- Prescribing blood products such as red blood cells and platelet transfusions
- Completing discharge summaries
- Communicating effectively with haematology patients and their families

Important Knowledge / Skills

Haematology specific skills and procedures include:

- Performing venepuncture and cannulation, including in patients with difficult access
- Assisting with and, where appropriate, performing bone marrow aspirates and trephine biopsies
- Prescribing and administering blood products safely
- Managing central venous lines (eg PICCs/ Hickmans) including accessing and troubleshooting
- Reviewing and interpreting blood films and basic haematological investigations

Common Conditions	Key Skills
Malignancies including acute/ chronic leukaemias, lymphomas, and multiple myeloma Haematological emergencies including neutropenic sepsis, tumour lysis syndrome, DIC Anaemias including iron deficiency anaemia, haemolytic anaemia and aplastic anaemia Bleeding disorders including coagulation disorders and thrombocytopenias Plus other haematology conditions such as sickle cell disease and thalassaemias	Targeted haematology examination (pallor, jaundice, petechiae, bruising, lymphadenopathy) Assess for organomegaly (esp splenomegaly and hepatomegaly) Recognise signs of acute illness (e.g. sepsis, bleeding, spinal cord compression) Assess performance status and general function Procedural skills as listed above Interpretation of haematology investigations Liaising with labs/ transfusion team/ specialists

Paediatrics

Dr. Mohammad Zulfiqar

Introduction to Paediatrics

Paediatrics in the North West is delivered across district general hospitals and tertiary centres such as Alder Hey and Royal Manchester Children's Hospital.

Foundation Year doctors play a key role in day-to-day ward care, acute assessment with seniors, communicating and liaising with tertiary centres and escalating unwell children.

Children can deteriorate rapidly, so clear communication with senior clinicians, nursing staff and families is essential. Early red flags and timely escalation are central to safe paediatric practice. Most paediatric departments will be supernumerary and consultant led throughout the day, with on-call consultants at stand by during the night.

Roles and Responsibilities as an FY1/2

- Attending and documenting ward rounds clearly
- Performing initial assessments using an A-E to approach
- Prescribing fluids, antibiotics and analgesia appropriate for weight and age
- Communicating with patients/carers regarding plans and progress
- Completing discharge summaries, safety netting and follow up advice
- Liaising with safeguarding, specialists and MDT teams

Important Knowledge / Skills

- Always document who you escalated to and when
- Weight is as important as age
- If you're worried, escalate – even if observations look “okay”
- Parents often know when something isn't right... listen to them
- Learn from seniors on how to do simple examinations and procedures in children such as bloods and cannulas

Common Conditions	Key Skills
• Bronchiolitis and viral wheeze • Asthma exacerbations • Sepsis and febrile illness • Gastroenteritis and dehydration • Neonatal jaundice • DKA and hypoglycemia • Seizures and febrile convulsions • Surgical/ ENT conditions such as appendicitis and tonsillitis	• Paediatric history and examination (including growth and development) • Recognition of the unwell child (PEWS use) • Safe prescribing (weight-based dosing) • Fluid management in children • Blood gases (capillary/VBG interpretation) • Clear escalation using SBAR • Communicating difficult information to families

Neonatology

Dr. Oyindamola Adeniyi

Introduction to Neonatology

There are 22 neonatal units in the North West of England. Neonatal services care for newborn babies who are critically unwell, often due to prematurity, multiple births (such as twins or more), low birth weight, or other medical complications.

Neonatal units can have varying degrees of care:

- Level I offers routine care for healthy newborns.
- Level II (special care nursery) supports preterm or unwell infants who require moderate care.
- Level III (NICU) delivers intensive treatment for critically ill babies.
- Level IV (regional NICU), provides advanced therapies and specialised surgical care.

Greater Manchester has 3 neonatal intensive care units and 5 local neonatal units. Cheshire and Merseyside has 2 neonatal intensive care units, 1 surgical unit, 5 local neonatal units and 1 Special Care Unit. Lancashire and South Cumbria has 2 neonatal intensive care units, 2 local neonatal units and 1 Special Care Unit.

Roles and Responsibilities as an FY2

- Attending ward rounds and documenting in electronic health records (e.g. Badger)
- Ordering, chasing, and interpreting blood tests, scans, and clinical reviews
- Completing comprehensive discharge summaries
- Liaising with family members and providing updates
- Supporting families in stressful or unexpected situations
- Liaising with local units and specialist services

Important Knowledge / Skills to Read About

You are likely to be supernumerary when working in neonatology as an FY. There are a range of learning opportunities, including neonatology-specific investigations and procedures that you can get involved in. Seniors are usually happy to teach where there is interest.

- Umbilical venous and arterial catheter (UVC/UAC) insertion and removal
- Arterial line insertion
- Assisting with procedures such as chest drain insertion in cases of pneumothorax (depending on unit exposure)
- Lumbar punctures (for suspected neonatal sepsis/meningitis, under supervision)
- Nasogastric tube insertion and feeding support initiation

Neonatology

Dr. Oyindamola Adeniyi

Common Conditions	Key Skills
Prematurity complications: respiratory distress syndrome, apnoea of prematurity, temperature instability, feeding difficulties Respiratory problems: transient tachypnoea of the newborn, meconium aspiration syndrome, need for CPAP or oxygen therapy Infections: suspected or confirmed neonatal sepsis, group B Streptococcus (GBS) exposure Jaundice: physiological jaundice, pathological jaundice requiring phototherapy or exchange considerations Metabolic and feeding issues: hypoglycaemia (especially in infants of diabetic mothers), poor feeding / weight loss, electrolyte imbalances Congenital or perinatal conditions: congenital anomalies (e.g. structural abnormalities), meconium-stained liquor with concerns for distress	• Newborn examination (routine newborn checks, NIPES and identifying abnormalities) • Blood sampling (capillary, venous, arterial gases) • Intravenous cannulation • Using new electronic systems like BadgerNet • Participating in deliveries requiring resuscitation support • Airway positioning, bag-mask ventilation (with supervision) • Interpreting blood gases, bilirubin, glucose levels, FBC, CRP • Initial management of suspected sepsis (cultures and prescribing antibiotics) • Managing hypoglycaemia • Reviewing chest X-rays and other imaging in newborns

Urology

Dr. Han Tran

Introduction to Urology

The urology services offered in hospitals across the North West of England depend on what facilities are available at each hospital. Urology specialises in comprehensive care for the urinary tract in both sexes and the male reproductive system. The majority of hospitals have an inpatient service and are equipped to manage urological emergencies and can refer to and discuss in MDTs with the major urological hubs when required, such as:

1. Manchester Royal Infirmary
2. Royal Liverpool University Hospital
3. Warrington and Halton Hospitals NHS Trust
4. Salford Royal Hospital

There will be frequent input from interventional radiology (if available locally) regarding nephrostomy insertions.

Roles and Responsibilities as an FY1/2

Expectations of a FY1/2 across all urological units:

- Prepare the list prior to ward round
- Attend and document ward rounds clearly
- Review unwell patients on the ward and escalate appropriately
- Order, vet, chase and interpret scans
- Perform and chase urgent investigations eg bloods, cultures, and ensure next day bloods are ordered
- Book relevant procedures – emergency and elective procedures
- Complete timely discharge summaries and discharge medications
- Update the list at the end of each day
- Ensure follow up scans and appointments are organised and outpatient referrals are completed

Important Knowledge / Skills to Read About

Urological specific tasks:

- Male and female catheter insertion
- 3-way catheter insertion
- Catheter changes
- Bladder washouts
- Nephrostomy removals
- Suprapubic catheter changes

Useful to read about:

- Common medications used in benign prostatic hypertrophy, eg. tamsulosin, finasteride
- Hormonal treatment in prostate cancer
- Hospital specific antibiotic guidelines for UTI and pyelonephritis

Urology

Dr. Han Tran

Common Conditions	Key Skills
• Visible haematuria • Benign prostatic hypertrophy • Oncology: bladder cancer, prostate cancer • Post-operative complications • Acute urinary retention • Testicular torsion • Urinary calculi • Infections: pyelonephritis, complicated UTI, epididymo-orchitis • Hydronephrosis • Overactive bladder	- Managing haematuria with irrigation and bladder washouts and deciding when to change from 3-way to 2-way catheter - Manage fluid and electrolytes abnormalities - Basic interpretation of relevant imaging, eg. US urinary tract, CT KUB - Testicular examination - Abdominal examination

Ear, Nose and Throat Surgery

Dr. Lydia Shone



Introduction to ENT

ENT is a great specialty to have during your FY1/2 years! All trusts across the North West have an ENT department, with paediatric ENT services offered at Royal Manchester Children's Hospital and Alder Hey Children's Hospital. As the number of foundation doctors completing medical school is increasing, more jobs are being created within ENT departments for foundation doctors. ENT is a fabulous job if you like a mixture of hands-on experiences, clinics and theatres.

ENT clinic services:

- E-clinics (often lead by SHOs)
- General clinics (often lead by registrars)
- Consultant led clinics (sub-specialist – for example, if a consultant specialises in ears, they will review issues related to ears, e.g. hearing loss, micro-suction, tinnitus, vertigo)

Roles and Responsibilities as an FY1/2

The role of FY1s and FY2s in ENT differs a lot. However, there is still plenty for you to get involved in! As an FY1, you tend to hold a supernumerary role, and are primarily involved in:

- Ward jobs (documentation, bloods, cannulas, prescribing regular meds, TTOs, liaising with other specialties)
- Reviewing acutely unwell patients on the ward (not always ENT specific issues)

However, there is a lot of flexibility. As you have more spare time, there is more time for you to join clinics and theatres. It is a perfect job if you want to build a surgical portfolio and get theatre time.

As an FY2, you are the SHO. You will be involved in:

- Running your own clinics (e-clinic - referrals from GPs or referrals from A+E that don't need admission)
- Assisting in theatre
- On-call shifts

During on-calls, you will hold a bleep and receive referrals from GPs or from A+E. It is a big jump from FY1 to SHO, however ENTSHO.com is an incredibly useful website created by ENT doctors to help support ENT SHOs. You will receive support from registrars and consultants who are around.

Important Knowledge / Skills

ENTSHO.com will be your best friend! It includes a wealth of knowledge on common conditions that you might encounter as a resident doctor working on ENT. It is a very hands-on specialty, and you will be taught plenty of skills.

Ear, Nose and Throat Surgery

Dr. Lydia Shone



Common Conditions	Key Skills
Ear: - Otitis media - Otitis externa - Foreign body removal - Hearing loss, tinnitus and vertigo (e.g. BPPV) Nose: - Epistaxis - Foreign body removal and nasal trauma - Septal haematoma Throat: - Tonsillitis - Quinsy - Post-tonsillectomy complications (bleeding and pain) - Airway issues – stridor, deep neck infections, angioedema - Thyroid issues (you will see a lot of neck lumps!)	Ear: - Otoscopy - Micro-suction - Incision and drainage - Dix-Hall-Pike and Epley manoeuvre Nose: - Nasoendoscopy - Silver nitrate cautery - Inserting/removing Rapid rhinos nasal packing Throat: - Nasoendoscopy – examining vocal cords - Incision and drainage of a quinsy - Examination of neck lumps and lymph nodes General: - ENT history taking - Reviewing audiograms, CT scans

Breast Surgery

Dr. Thevaguru Swarnaprabha

Introduction to Breast Surgery

Breast Surgery is delivered by multiple centers across North West England with primary focus being on diagnostics and management of breast cancer. As most procedures are day cases, Breast Surgery is primarily an out-patient based department with occasional overnight stays for more complex surgeries and occasional unwell patients.

Roles and Responsibilities as an FY1/2

Breast Surgery is primarily consultant led so your main activities will include supporting the day-to-day functioning of the Breast Unit. This will likely include:

- Pre-operative Assessment & liaison with Anaesthetics.
- Assisting in theatres particularly in cases of bilateral breasts.
- Prepare patients for Theatre/VTE Assessments & Discharge Summaries.
- Supporting Nurse Led Clinics through prescriptions of analgesia or antibiotics & assessments.

In general, the consultants are very approachable and want to be told sooner rather than later if there's any concerns of questions about one of their patients so are more than happy to help.

Depending on the trust you work in you will likely also have general surgical on-calls to cover outside of your standard days on Breast Surgery.

Important Knowledge / Skills

Management of Breast Abscesses:

- Be aware of your local trusts pathway for managing a breast abscess as this will be your main call to see unwell patients (N/B some trusts have General Surgery look after these patients).

Pre-operative Assessments:

- UK Clinical Pharmacy Associations Handbook of Perioperative Medicines is useful for pre-op medications. (1)
- British Association of Anaesthetics tend to accept a blood pressure of less than 160/100 perioperatively - Often it is elevated at pre-operative clinic due to anxiety about surgeries. (2)
- Check local anaesthetic referral guidelines and act accordingly. If in any doubt with any part of the assessment, liaise with anaesthetists typically via secretary email for questions or referrals.

General Surgical On-Calls (if at your trust):

- The stark difference from the day job means this will be the hardest part of your rotation.
- Liaise with Peer F1s on General Surgery who are more familiar with local trust specifics of on-calls for advice.
- Familiarise yourself with local order-sets, locations of wards, protocols, and policies before your first on-call to allow for a smoother transition

Breast specific knowledge is not necessary unless you are keen to get very involved in theatres or run your own supervised clinics. This is also an optimal rotation to get cases up for those looking to apply to Core Surgical Training as there are ample opportunity to not just scrub in but also suture & dissect!

1. UK Clinical Pharmacy Associations Handbook of Perioperative Medicines 2026. <https://periop-handbook.ukclinicalpharmacy.org>

2. Association of Anaesthetists of Great Britain and Ireland. The measurement of adult blood pressure and management of hypertension before elective surgery 2016. Anaesthesia 2016; 71: 326-337.

Vascular Surgery

Dr. Giulia Guzzon

Introduction to Vascular Surgery

Vascular surgery in the North West of England is organised through a regional specialist network, with complex care delivered in high-volume centres supported by local hospitals. It combines open and endovascular techniques and involves close multidisciplinary working, especially in the care of patients with significant comorbidities.

The major vascular surgery centres in the North West of England are:

- Aintree University Hospital, Liverpool
- Manchester Royal Infirmary
- Royal Preston Hospital
- Wirral/West Cheshire/Warrington network, led by Countess of Chester Hospital

Roles and Responsibilities as an FY1

Responsibilities as an FY1 on vascular surgery:

- Prepare the list/notes for ward rounds, including the latest scan and blood results, and management plans.
- Attend and document ward rounds.
- Request and chase scans, bloods and pre-operative investigations to help the team plan the best management for each patient.
- Review deteriorating patient and escalate when appropriate.
- Complete discharge summaries and update relatives.

Important Knowledge / Skills

Vascular surgery patients are often elderly and comorbid. It is important as an F1 to be able to recognise early deterioration and post-operative complications. You might want to review the most common ones: bleeding, sepsis, graft occlusion, graft infection, compartment syndrome, AKI, delirium, chest infections.

The most common ward skills that you will learn to perform are:

- Venepuncture
- Cannulation
- ABG/VBG
- ECG interpretation
- Bedside Doppler and peripheral pulses assessment

Vascular Surgery

Dr. Giulia Guzzon

Common Conditions	Key Skills
Peripheral artery disease: intermittent claudication, chronic limb-threatening ischaemia, acute limb ischaemia Aortic disease: AAA, thoracic aortic aneurysm, aortic dissection, endovascular aortic aneurysm repair (EVAR)/ thoracic EVAR/ open repair Diabetic foot and neuroischaemic foot: foot ulcers, wet/dry gangrene, cellulitis Carotid artery disease: TIA, stroke, symptomatic carotid stenosis, carotid endarterectomy Venous disease: DVT, venous ulcers, varicose veins Dialysis access problems: arteriovenous fistula, fistula failure, infected access	- Recognise early post-operative complications (e.g. bleeding, graft occlusion) - Limb perfusion examination - 6 Ps of acute limb ischaemia: pain, pallor, pulselessness, paraesthesia, paralysis, poikilothermia - Wound assessment (discharge, bleeding, surrounding erythema, dehiscence, early signs of infection) - Fluid balance and renal function assessment - Safe prescribing of VTE prophylaxis pre- and post-op - Anticoagulation and antiplatelet medications - Pain management - Palliative care and anticipatory medications

Neurosurgery

Dr. Shona Buckley

Introduction to Neurosurgery

Neurosurgery in the North West of England is delivered through a network of large tertiary centres that receive referrals from district general hospitals across the region. Neurosurgical patients can deteriorate rapidly so early recognition of concerning signs, prompt escalation and clear documentation are essential.

There are three major Neurosurgical centers in the North West of England:

1. Salford Royal Hospital (Northern Care Alliance)
2. Royal Preston Hospital (Lancashire Teaching Hospital)
3. The Walton Center (Liverpool)

Roles and Responsibilities as an FY1/2

Expectations of a FY1/2 across all Neurosurgical Units include:

- Attending ward rounds and documenting clearly
- Initial reviews of unwell patients and escalating appropriately
- Order, chase and interpret basic investigations/scans
- Prepare patients for theatre
- Complete discharge summaries and communicate with family members

Important Knowledge / Skills to Read About

Neurosurgery specific tasks (If you are keen to learn how to do these procedures, you will be taught so that by the end of the rotation you can do them independently. Equally, if you don't want to learn then a senior will do them):

- Removing drains including subdural and lumbar
- Removal of external ventricular drains (EVDs)
- Insertion/removal of intracranial pressure (ICP) bolts
- Lumbar punctures
- Adjustment of shunts

Common Conditions	Key Skills
Trauma: traumatic brain injury, acute subdural/extradural haemorrhage, traumatic subarachnoid haemorrhage, skull fractures Oncology: primary and metastatic tumours. Most commonly meningiomas, gliomas and pituitary tumours Spines: cauda equina, spinal tumours, metastatic spinal cord compression Vascular: aneurysms, arteriovenous malformation Functional: epilepsy Skull base: pituitary tumours, apoplexy	Full neurosurgical examination (GCS, cranial nerves, upper/lower limb) Recognise red flags e.g. raised ICP Interpret basic scans e.g. CT head/ MRI spine Recognition of UMN/LMN signs Manage fluid and electrolytes (especially sodium) Seizure management including status epilepticus

Trauma and Orthopaedics

Dr. Davina Vadher

Introduction to Orthopaedics

The North West of England is comprised of a network of hospitals with major trauma centres including Aintree University Hospital, Manchester Royal Infirmary, Salford Royal Hospital and Royal Preston Hospital. These hospitals accommodate complex polytrauma patients and referrals from smaller district general hospitals.

Orthopaedics is a fast-paced department with high-patient turnover. It consists of ward-based care, complex patients requiring many teams, elective cases, outpatient clinics, physiotherapy, and rehabilitation. The department relies heavily on multi-disciplinary working to facilitate the patient journey. This includes the ortho-geriatrics team who support complex elderly patients with fractures. The team also consists of trauma coordinators who facilitate patient flow.

Roles and Responsibilities as an FY1/2

F1: Mainly ward-based: documenting on ward rounds, updating ward lists, responsible for the day-to-day ward care including interpreting bloods, ordering scans and chasing tasks, responding to nursing concerns, reviewing acutely unwell patients and escalating accordingly, completing discharge summaries, and updating patients and families. Occasional theatre experience. On-calls comprise of ward cover and involve managing unwell patients and acute concerns.

F2: In addition to the F1 role they are also responsible for 'carrying the bleep' for referrals, clerking, being a point of contact for F1s to provide advice, attending supervised clinics and assisting in theatre.

Important Knowledge / Skills

You will be interpreting post-op blood results daily, prescribing VTE prophylaxis/analgesia/laxatives/ antiemetics, interpreting basic post-op X-rays, and conducting thorough A to E examinations and wound reviews.

By the end of the rotation, as well as basic skills (venepuncture, cannulation etc), you will be expected to know the different indications for casts, braces and slings, understand basic management for common conditions, and follow up the post-op plans (VTE duration, weight bearing status and clinic follow up).

Trauma and Orthopaedics

Dr. Davina Vadher

Common Conditions	Key Skills
• Trauma: neck of femur fractures, ankle fractures, distal radius fractures, humeral fractures, septic arthritis, tendon ruptures • Spine: cauda equina syndrome, vertebral compression fracture, spinal cord compression. • Emergencies: compartment syndrome, autonomic dysreflexia, metastatic spinal cord compression, sepsis, and wound/bone infections. • Elective: joint replacements/arthroplasty, removal of metal work, and carpal tunnel surgery.	• A–E assessment: structured assessment and recognition of early deterioration. • Recognising orthopaedic emergencies and understanding escalation protocols • Neurovascular examination: assessing pulses, capillary refill, motor and sensory function • Managing fluid balance and electrolyte disturbances • Scrubbing up and suturing • Liaising with departments (vascular, plastics, medics) and other hospitals (repatriations)

Orthogeriatrics

Dr. Mohsin Sadiq

Introduction to Orthogeriatrics

Orthogeriatrics is a collaborative service between orthopaedics and geriatric medicine, focused on providing holistic care to older adults (typically aged 65 years and over) who are admitted with hip fractures or other fragility fractures. Orthogeriatric input centres on medical optimisation, peri-operative care and secondary fracture prevention. It is a rewarding rotation for those who enjoy general and acute medicine, offering exposure to a broad range of medical conditions in a complex and frail patient population.

In most orthogeriatric departments across the North West, patients remain under the primary care of orthopaedics. Orthogeriatric teams review appropriate patients and provide targeted medical input as required, working closely with surgical teams to optimise outcomes.

Roles and Responsibilities as an FY1/2

- Ensuring all appropriate patients receive a senior orthogeriatric review within 72 hours of admission, ideally pre-operatively
- Conducting comprehensive medical assessments of patients
- Identifying, managing and escalating common peri-operative and post-operative complications (e.g. delirium, AKI, electrolyte disturbances, infection)
- Ordering and chasing investigations
- Communicating clearly and compassionately with families, providing updates and addressing concerns
- Clear documentation of best interest meetings, family discussions and ward round entries
- Supporting discharge planning and follow-up arrangements, including referrals to falls services and community osteoporosis / bisphosphonate / rheumatology clinics

Important Knowledge

- You will work closely with the MDT (physiotherapists, occupational therapists, speech and language therapists, diabetic nurses, anaesthetics, palliative care and dieticians)
- Frailty screen usually refers to the following bloods: FBC, U&Es, LFTs, bone profile, B12 + folate, iron studies, magnesium, creatinine kinase (if long lie) and a myeloma screen

Common Conditions	Key Skills
• Hip fractures • Osteoporosis • Delirium • Falls and frailty syndromes • Dementia and cognitive impairment • Multimorbidity (HF, AF, COPD, CKD) • Post-op complications (AKI, infection, anaemia) • End-of-life care • Aspiration pneumonia • Dysphagia • Diabetes • Hypertension	• Comprehensive geriatric assessment • Delirium screening and management • Capacity assessments • Safe medication review and deprescribing • Escalation planning and DNACPR discussions • Difficult venepuncture / cannulation • ECG / chest x-ray interpretation • Arterial blood gas sampling • Teamwork with the MDT • Nasogastric tube insertion • Identifying contraindications to bisphosphonates

Oral & Maxillofacial Surgery

Dr. Eve Butler

Introduction to Oral & Maxillofacial Surgery (OMFS)

Oral & maxillofacial surgery is a highly specialised surgical field, involving head and neck oncology, trauma, deformity, and dentoalveolar surgery.

In the North West of England, five hospitals offer various services under the speciality:

1. **North Manchester General Hospital** is a tertiary centre, treating over 100 major head and neck cases per year.
2. **Manchester Royal Infirmary** is also a tertiary centre and supplies a Cleft Lip and Palate Unit based at Royal Manchester Children's Hospital.
3. **Royal Blackburn Hospital** covers trauma and deformity and orthognathic surgery, and has an established robotic surgery service.
4. **Royal Preston Hospital** is a major trauma centre with oral and maxillofacial services.
5. **Wythenshawe Hospital** provides oral & maxillofacial services.

Roles and Responsibilities as an FY1/2

Expectations of an FY1/2 in OMFS may include:

- Supporting the daily ward round, including pre- and post-operative patients
- Attending MDTs with doctors, SLTs, oncology nurses, etc.
- Providing basic medical management of patients
- Support theatre cases through practical support as well as post-operative documentation and discharge summaries
- Support in daily clinics, assisting with extractions, pre-op reviews and trauma cases.

Important Knowledge / Skills

OMFS is often a supernumerary placement for foundation doctors, so you may get opportunities to spend time in theatre. It is a great opportunity to improve basic medical and surgical skills such as:

- Suturing
- Insertion of feeding tubes
- Catheter insertion
- Surgical drain insertion and removal

Many patients leave major head and neck cancer operations with temporary tracheostomies. It is important to understand how this airway is inserted, its indications, monitoring points, and ways of weaning/removing the airway.

Oral & Maxillofacial Surgery

Dr. Eve Butler

Common Conditions	Key Skills
Oncology: head and neck cancers are usually squamous cell carcinomas, and can occur in the mandible, tongue, palate, and so on. Risk factors are mainly smoking and alcohol, with HPV-16 being an important factor for tonsil or tongue cancers. Trauma: fractured mandibles, orbital floor fractures, tooth avulsion, zygomatic fractures, Le Fort fracture. Dental: dental abscesses, Ludwig's Angina	Understand the surgical approach to such cancers, mainly wide local excision, neck dissections, and free flaps. Gain a basic understanding of tracheostomies; when they are inserted, how they are managed, and the approach to emergencies. Understand the approach to OMFS trauma, red flags for urgent surgical intervention and safeguarding. Understand the indications for dental extraction and red flags for Ludwig's Angina.

Ophthalmology

Dr. Jacob Morning

Introduction to Ophthalmology

Ophthalmology units are generally day case wards with no inpatient beds. Units generally cover large regions of patients, so clinics and theatre lists are often quite full. Patients will attend elective surgeries and clinics as well as casualty clinic after referral from A&E. You will generally take on a supernumerary role in ophthalmology, working closely alongside specialty doctors.

The main eye units with FY1/2 posts are:

- Manchester Royal Eye Hospital
- Royal Blackburn Hospital
- Rochdale Infirmary

Roles & Responsibilities Day to Day

- Generally, you will start the day helping to prepare patients for their surgeries, prescribing and administering eye drops, assessing abnormal pre-op observations and prescribing VTE prophylaxis.
- You may or may not be involved in the consenting of patients for their surgeries.
- Elective cataracts and vitrectomy surgeries will require dilating eye drops (e.g., phenylephrine, cyclopentolate and/or tropicamide).
- Post-op drop prescription can be consultant specific; it is best to ask to see what they would prefer for each procedure.
- For any cancelled surgeries (abnormal HbA1c/BM levels, did not attend, abnormal obs), you will need to write to their GP.
- Any patients requiring an overnight stay will likely be transferred to a different ward. You will need to ensure their regular medications are prescribed.
- You may be required to complete patient discharge summaries after their procedures, advising on post-op care.
- Additionally, the doctors running the casualty clinics may ask you to vet scans/take bloods for patients they've seen (for any special bloods e.g. TB or HLA-B27 ask the nurses/technicians for the bags and bottles).
- If you join casualty clinics you may clerk and initially assess patients.
- You may also be required to sign prescriptions throughout the day including injection prescriptions.

Important Info

- Take this placement as an opportunity to progress your portfolio and learn new skills that you wouldn't commonly come across.
- You should have time to attend clinics and assist in theatres (e.g., squint patients).
- Use this time to learn and practice slit lamp examinations and fundoscopy as well as getting CBDs, mini-CEXs and DOPS signed off.
- The SHOs, registrars and consultants will often be doing audits and should be happy to involve you in data collection.

Ophthalmology

Dr. Jacob Morning

Common Conditions	Key Skills
Elective cataracts Glaucoma Foreign bodies Corneal abrasions/ulcer Eye trauma Anterior uveitis Optic neuritis Conjunctivitis	Venepuncture Cannulation Vetting CT scans Examining abnormal obs eg postural drops, hyper/hypotension, bradycardia +/- referring to SDEC

Transplant Surgery (Renal)

Dr. Áine Hayes

Introduction to Transplant Medicine

Kidney transplantation in the North West of England is delivered by two tertiary transplant centres

- Manchester Royal Infirmary
- Royal Liverpool Hospital.

These centres work closely with multiple district general hospitals and regional dialysis units, which support patients requiring maintenance dialysis to sustain life while awaiting transplantation or if transplant is not suitable.

Patients with established kidney failure are clinically vulnerable and can deteriorate rapidly. Following transplantation, the ongoing immunosuppression places patients at continued risk of acute illness and rapid clinical decline - even with minor infections. Early recognition and prompt management of deterioration are therefore essential.

It's a unique team with both surgical (transplant surgeons) and medical (renal) input daily meaning there are so many opportunities to learn and get involved!

Roles and Responsibilities as an FY1

- Attend and contribute to daily ward rounds ensuring clear, accurate documentation of plans
- Perform initial reviews of unwell patients, initiate immediate management, and escalate promptly
- Review, request and chase investigations – bloods, tacrolimus levels, imaging
- Clerk new admissions for transplant surgery – both donors and recipients.
- Reconcile admission medications – ensure immunosuppression and high-risk drugs prescribed appropriately
- Ensure pre-operative investigations are done and documented – bloods, crossmatch, ECGs
- Complete clear, accurate and timely discharge summaries – operation details, immunosuppression + plan, follow up arrangements
- Update patients and families of progress and ensure understanding of treatment plans.

Important Knowledge

Recognition of unwell renal patient

- Immunosuppressed patients may not mount a typical inflammatory response in infections / sepsis
- Understand and recognise AKI, delayed graft function and features of rejection

Immunosuppression

- Familiarity with common immunosuppressive medications – tacrolimus, mycophenolate, prednisolone
- Importance of strict timing of drug levels (tacrolimus and ciclosporin)
- Recognise side effects (nephrotoxicity, neurotoxicity, bone marrow suppression) and drug interactions

Post-op complications

- Urine output monitoring immediately post-transplant (first sign of function)
- Recognise bleeding, thrombosis, urine leak and wound infections – complications of surgery

Infection risk and prophylaxis

- Awareness of opportunistic infections – cytomegalovirus, BK virus, pneumocystis pneumonia
- Local antimicrobial guidelines and prophylactic regimens

Transplant Surgery (Renal)

Dr. Áine Hayes

Common Conditions	Key Skills
Primary function / delayed graft function Declining graft function Acute rejection (cellular or antibody mediated) Dialysis – haemodialysis / peritoneal dialysis UTIs Fluid overload Electrolyte disturbances – hyperkalaemia, hyponatraemia, metabolic acidosis Anaemia (of CKD) Post-transplant diabetes	Assessment of fluid status Abdominal examination – including palpation of graft Interpretating blood results and scan results – actioning their findings Neurological examination – ?encephalitis ?immunosuppression toxicity Bloods / cannulas - don't take from fistula arm!!!

Obstetrics and Gynaecology

Dr. Sophie James

Introduction to Obstetrics and Gynaecology

Obstetrics and gynaecology involves the care of patients during pregnancy, birth, and the postnatal period, and with conditions affecting the female reproductive system. The specialty combines medical management, surgical skills, and emergency care, and on-call shifts can be time-pressured and stressful! This role requires prompt recognition and review of deteriorating patients with early escalation to senior colleagues, strong communication skills, and effective multidisciplinary team-working with midwives, anaesthetists and neonatal teams.

In the North West, there are several key health centres providing O&G services, including Liverpool Women's Hospital, which is the largest single-site maternity hospital in the UK, and Saint Mary's Hospital in Manchester, which is a regional referral centre for specialist gynaecological care.

Roles and Responsibilities as an FY1/2

- Initial review of patients in Obstetric Triage and Emergency Gynaecology Unit
- Inpatient reviews for antenatal/postnatal/gynaecology ward patients
- Review of acutely unwell patients and initial investigation/management
- Completing and documenting full obstetric/menstrual/sexual histories
- Scrubbing and assisting in emergency and elective theatres
- Completing discharge summaries and TTOs

Important Knowledge / Skills

As a resident doctor in O&G, you will be involved in acute presentations and emergency care, chronic disease management, and surgery. Common conditions and clinical and procedural skills which would be useful to prepare include:

Common Conditions	Key Skills
• Pre-eclampsia • Gestational hypertension • Gestational diabetes • Nausea and vomiting in pregnancy/hyperemesis gravidarum • Ectopic pregnancy • Endometriosis • Ovarian torsion • Sepsis	• Key histories – obstetric history, menstrual history, sexual history, screening history • Obstetric abdominal examination • Speculum examination • Bimanual examination • Performing high vaginal swabs • Scrubbing Common theatre procedures • Caesarean section • Instrumental delivery • Hysterectomy • Myomectomy • Excision of endometriosis • IUD/IUS insertion/removal

Anaesthetics

Dr. Rebecca Webster

Introduction to Anaesthetics

Anaesthetics jobs are available in both large teaching hospitals and district general hospitals. It is usually an FY1 rotation. It provides exposure to a wide variety of anaesthetic techniques and a chance of gain insight into job of an anaesthetist. It is a unique opportunity to gain and practice procedural skills and develop anaesthetic knowledge.

There are currently 5 hospitals in the North West that have anaesthetics jobs:

1. Blackpool Victoria Hospital (Blackpool Teaching Hospitals)
2. Royal Blackburn Teaching Hospital (East Lancashire Hospitals)
3. Tameside Hospital (Tameside and Glossop Integrated Care)
4. Royal Oldham Hospital and Rochdale Day Surgery Unit (Northern Care Alliance)
5. Royal Albert Edward Infirmary (Wrightington, Wigan and Leigh)

Roles and Responsibilities as an FY1

Supernumerary role under consultant supervision:

- Exposure to a broad range of surgical specialties
- Experience in both day-case, elective and emergency theatres
- Opportunity to develop practical skills and understanding of anaesthetic practice
- **Pre-operative assessment**
 - Review patients pre-operatively and communicate the anaesthetic plan to patient
 - Participate in clinical decision-making
- **Theatre participation**
 - Attend and contribute to the WHO surgical safety checklist
 - Aid positioning in theatre
 - Prepare and draw up anaesthetic medications
- **Other skills (supervised)**
 - Spinal anaesthesia
 - Arterial line insertion

Important Knowledge / Skills

Core Knowledge	Keys Skills	Core Drugs
• Principles of respiratory physiology and mechanisms of breathing • Physiological effects of general anaesthesia • Difficult airway management • Basics of ventilator function and settings • Spinal anatomy relevant to neuraxial anaesthesia	• Cannulation of patients on arrival to theatre • Assist with/perform airway management: bag-valve-mask ventilation, insertion of supraglottic airways (e.g. i-gel), and endotracheal intubation	• Muscle relaxants and reversal agents • Induction agents • Volatile anaesthetic gas • Anti-emetics and analgesics

Intensive Care Medicine

Dr. Caitlin Ryder

Introduction to ICU

Intensive Care Medicine in the North West of England is delivered across well-established regional networks, with major tertiary centres supported by district general hospitals. ICU services cater to a diverse population requiring complex multi-organ support, including patients with respiratory failure, sepsis, post-operative complications, trauma, and multi-system critical illness.

Tertiary and specialist ICU centers within the North West of England:

- Manchester Royal Infirmary – leading tertiary ICU with expertise in advanced organ support, including extracorporeal membrane oxygenation, renal replacement therapy (RRT), and complex post-surgical critical care, closely integrated with surgery, cardiology, and interventional radiology.
- Royal Liverpool University Hospital – major regional ICU providing high-dependency and intensive care services for Merseyside and surrounding areas, including specialist cardiac, neurological, and post-operative surgical critical care.

Roles and Responsibilities as an FY1/2

Expectations of a FY1/2 across all intensive care departments include:

- Following ward rounds and documenting clearly
- Recognizing unwell patients and escalating early
- Order, chase and interpret investigations
- Monitor fluid charts including catheter and drain outputs
- Prepare patients for theatre and care for them post-operatively
- Complete discharge summaries on ICU stepdown and ensure clear handover to ward teams

Important Knowledge / Skills

- Working closely with other members of the MDT including specialist and ICU nurses, dieticians and nutritionists, respiratory therapists, speech and language teams, and surgeons
- Assisting with advanced clinical skills including central and arterial line insertion, ascitic drains and chest drain insertion and intubation
- Nutrition and organ support decisions

Common Conditions	Key Skills
Respiratory failure: acute respiratory distress syndrome, pneumonia, COVID complications, COPD exacerbation Sepsis and multi-organ failure: septic shock, systemic inflammatory response syndrome Cardiovascular: cardiogenic shock, myocardial infarction complications, arrhythmias Neurological: stroke, status epilepticus, raised intracranial pressure Surgical patients: major surgery recovery, trauma patients, post-operative complications Renal and metabolic disorders: AKI, electrolyte disturbances, diabetic ketoacidosis	• Venepuncture, cannulation, US guided access, catheterisation, NG tube insertion, and basic wound care • Monitoring and recording of ventilatory settings, vital signs, and fluid charts • Awareness of organ support, including ventilation, inotropes, vasopressors, and RRT • Recognising deterioration and escalating to seniors • Recognising post-operative complications and ventilator-associated complications

Microbiology

Dr. Ugonma Ogunleye

Introduction to Microbiology

Microbiology is a medical specialty focused on the diagnosis, management, and prevention of infectious diseases. As a foundation doctor in microbiology, you will take a predominantly advisory role, supporting clinical teams in the interpretation of lab results and the optimisation of antimicrobial therapy.

You will gain insight into infection management across a wide range of specialties, whilst developing skills in clinical reasoning, communication, and antimicrobial stewardship. The placement also provides valuable exposure to infection prevention and control practices, as well as the broader role of microbiology in improving patient outcomes and public health.

Roles and Responsibilities as an FY1/2

- Reviewing microbiology results (e.g. cultures, sensitivities, PCR) and identifying clinically significant findings
- Discussing cases with senior microbiologists and contributing to clinical decision-making
- Providing advice to clinical teams on antimicrobial choice, dosing, and duration (with senior support)
- Assisting in the management of common infections and escalation of complex cases
- Participating in multidisciplinary discussions with clinicians, pharmacists, and infection control teams and attending ward rounds, MDT meetings, and teaching sessions where available

Important Knowledge / Skills

Common Conditions	Key Skills
• Urinary tract infections (UTIs) - including recurrent and resistant cases • Respiratory tract infections (e.g. community- and hospital-acquired pneumonia) • Skin and soft tissue infections (e.g. cellulitis, wound infections) • Bloodstream infections (bacteraemia) and sepsis • Gastrointestinal infections (including <i>C.difficile</i>) • Hospital-acquired infections and outbreak management • Device-related infections (e.g. line infections, catheter-associated UTIs) • Bone and joint infections (e.g. osteomyelitis, septic arthritis) • Central nervous system infections (e.g. meningitis) • Infections in immunocompromised patients • Antimicrobial-resistant infections (e.g. MRSA, ESBL-producing organisms)	The CLIPPED framework ensures a structured way to approach microbiology results whether it is blood cultures, swabs, urine results, etc. • Clinical – presenting complaint, history, examination • Laboratory – blood results, other cultures, screening results • Imaging – any radiological imaging or suggest further imaging if appropriate • Infection Prevention and control – Is there any specific advice applicable to the current case? Do the Infection Prevention team need to be made aware? Any precautions for the ward staff? • Public Health – Is this a notifiable disease? • Prescribing – What antibiotics are/were they on? Any allergies, side effects, further monitoring? • Evaluation – What is the plan that you will relay to the clinical team? • Diagnosis – Current working diagnosis

Radiology

Dr. Ankush Santosh

Introduction to Radiology

Radiology plays a pivotal role in the assessment and triage of patients across a wide range of specialties. Imaging is fundamental in determining disease severity and progression, as well as in guiding both medical and surgical management. Furthermore, interventional radiology (IR) provides minimally invasive alternatives to traditional open surgical procedures.

As such, it is essential for clinicians to develop the ability to recognise a broad spectrum of imaging findings and to interpret them within the context of the patient's clinical presentation.

Roles and Responsibilities as an FY1

As the radiology FY1, you are not expected to formally report imaging studies. However, you are expected to:

- Develop the ability to interpret basic imaging, including chest x-rays (CXR), abdominal x-rays (AXR), and CT head scans for acute pathology such as intracranial haemorrhage
- Provide support to the radiography team when required. For example, performing IV cannulation for contrast studies
- Participate in MDT meetings and REALM (Radiology Events and Learning Meetings) sessions.
- Attend IR procedures and assist with tasks such as transducer positioning under supervision

Important Knowledge / Skills

There are certain findings that you may be expected to recognise, as outlined in the table below. However, as this is primarily a learning role, senior colleagues will be available to provide guidance and support in identifying relevant imaging features and patterns.

Common Conditions	Key Skills
CXR: pneumonia, atelectasis, pneumothorax, pulmonary oedema, pleural effusion, rib fractures	Systematic interpretation of chest radiographs (CXR); assessment of lung fields, pleura, and bony structure
CT thorax: saddle pulmonary embolism, bronchiectasis, end-stage lung fibrosis	Interpretation of lung CT; identification of Ground Glass Opacification (GGO), consolidation, honeycombing and reticulation patterns and filling defects in central vessels
AXR: Bowel obstruction, toxic megacolon, pneumoperitoneum	Interpretation of abdominal radiographs (AXR); identification of imaging patterns such as pneumoperitoneum, bowel gas distension and transition points, and faecal loading
CT head: Intracranial haemorrhage, space-occupying lesions, skull fractures	Interpretation of CT head; differentiation of haemorrhage types, assessment of mass effect and midline shift

Psychiatry

Dr. Arun Dight

Introduction to Psychiatry

Psychiatry in the North West of England is split across different mental health trusts in three regions: Manchester, Lancashire, and Mersey & Cheshire, providing support across the following subspecialties:

- General Adult Psychiatry
- Older Adult Psychiatry
- Child and Adolescent Psychiatry
- Substance Misuse
- Psychiatry of Intellectual Disability
- Forensic Psychiatry

Roles and Responsibilities as an FY1/2

Most established psychiatry posts in FY1/2 exist in general adult psychiatry. Other clinical environments can include older adult psychiatry, liaison and some community settings. Jobs across these subspecialties may include:

- Assessment and review of patients in discussion with senior doctors in a variety of settings (inpatient wards, outpatient clinics, home visits, seclusion suites)
- Prescribing of agreed medication plans with senior, common physical medications, and transcribe of GP repeat prescriptions
- Regularly the first port of call for any physical health concerns, performing relevant physical examinations, investigations and enacting on subsequent management and referrals.
- Contribution in MDT settings to assist towards discharge planning; Admission clerking, mental state examinations, risk assessments, ward round documentation, discussion/presentation of cases
- Detainment of patients; section 5(2) under the mental health act (FY2 only)

Important Knowledge / Skills to Read About

Opportunities may arise to acquire psychiatry specific competencies beyond the Foundation Programme, such as:

- Psychotherapy experience
- Additional emergency experience (involvement/observation of a 136 assessment or seclusion review)
- Micro-legal experience (observation of a Mental Health Tribunal or Mental Health Act Assessment)
- Observation or undertaking of Electroconvulsive Therapy (ECT)

Further information on "[Making the most of your psychiatry placement](#)" can be found on the Royal College of Psychiatrists website.

Psychiatry

Dr. Arun Dight

Common Conditions	Key Skills
Various psychoses: Schizophrenia, depression, schizoaffective, substance misuse, delirium, etc Depressive episodes: Crisis admissions for suicide attempts / self-harm Bipolar Disorder: Type 1: Mania, Type 2: Hypomania Personality Disorders: Emotionally Unstable Personality Disorder (EUPD) Behavioral and psychological symptoms of dementia: Alzheimer's, Vascular, Lewy Bodies, Frontotemporal, Parkinson's Eating Disorders: Anorexia, Binge Eating, Bulimia Somatisation Disorders ADHD & Autism	ECG: How to obtain and read one Phlebotomy: Patients may require regular monitoring (e.g. clozapine, lithium) Mental Health Act: Understanding the different legal statuses of patients Medications: Aware of common antidepressants and antipsychotics and the subsequent side effect profiles and monitoring requirements Primary Care Presentations: Aware of common physical health presentations as usually first point of call, recognising your competency and escalating where appropriate Communication: Regularly involved in mental state examinations (MSE), risk assessments, patient education, conflict and deescalation

Psychiatry – Later Life and Memory Services (LLAMS)

Dr. Elizabeth O'Shea



Introduction to LLAMS

Later Life Assessment and Management (LLAMS) services in the North West of England are delivered through a network of inpatient units and community teams that support older adults with complex mental health and cognitive disorders. These services receive referrals from acute hospitals, GPs, and community teams across the region. Patients generally have memory problems that can manifest as behavioural and psychological symptoms of dementia. These require inpatient management when they become high risk. As a foundation doctor, you will likely work on a secure inpatient ward. On the ward, the team make an assessment and diagnosis, and, if available, begin treatment. Your role as a foundation doctor on an old age ward largely centres around physical health – monitoring and managing day to day problems and knowing when to escalate to A+E if the patient's physical health needs become too great. However, it is important to know, LLAMS also includes memory clinics, community mental health teams for older adults, and input from liaison psychiatry to acute hospitals.

There are several major providers of LLAMS services in the North West of England:

1. Greater Manchester Mental Health NHS Foundation Trust
2. Mersey Care NHS Foundation Trust
3. Lancashire and South Cumbria NHS Foundation Trust
4. Cheshire and Wirral Partnership NHS Foundation Trust

Roles and Responsibilities as an FY1/2

- Regular ward round documentation
- Prescription of antipsychotic and memory medication under guidance of consultant psychiatrist
- Liaise with the MDT for holistic care of the patient
- Be involved in discussions regarding most appropriate care setting for each patient when they leave the ward
- Regular mental state examinations including formulating a patient's unique risk profile
- Complete and clearly document a capacity assessment
- Assessment, diagnosis and treatment of physical health conditions
- Management of medical emergencies
- Discuss complex cases and seeking advice from the medical registrar on call at the acute hospital
- Complete discharge summaries and TTOs
- Take blood samples independently
- Perform and interpret ECGs

Important Knowledge / Skills

Be familiar with these different types of dementia before starting on your rotation:

- Alzheimer's dementia
- Vascular dementia
- Lewy body dementia
- Parkinson's associated dementia
- Korsakoff's dementia
- Mixed dementia
- Young onset dementia – this can be any type
- Frontotemporal dementia

Psychiatry – Later Life and Memory Services (LLAMS)

Dr. Elizabeth O'Shea



Common Conditions	Key Skills
• Delirium - acute confusion, fluctuating cognition (often a reversible cause) • Behavioral and psychological symptoms of dementia (BPSD) • Depression in older adults • Falls/frailty syndromes • Common medical issues – AKI, UTI, LRTI • Constipation	• Recognise delirium vs. dementia • Under guidance of a senior, manage agitation using non-pharmacological and pharmacological approaches • Identify atypical presentations – eg. somatic symptoms • Assess falls risk and contributing medical factors • Early identification and treatment of causes of deterioration

Liaison Psycho-Oncology

Dr. Sophie James

Introduction to Liaison Psycho-Oncology

Liaison Psycho-Oncology in the North West of England is delivered at The Christie, which is the largest single site cancer centre in Europe. A large proportion of patients with cancer require psychiatric input throughout their cancer journey, with issues such as difficulty adjusting to diagnosis, depression/anxiety related to diagnosis, mental health affecting ability to engage with treatment, or pre-existing mental health conditions.

Roles and Responsibilities as an FY1/2

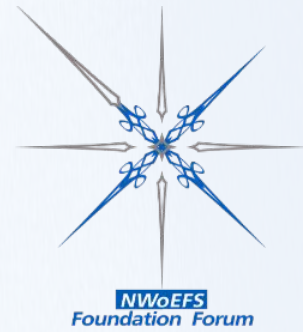
Expectations and responsibilities in Psycho-Oncology include:

- Initial review of new inpatient referrals
- Inpatient follow-up
- Completing and documenting a full psychiatric history and Mental State Examination
- Presenting cases at board round
- Presenting complex cases at weekly MDT meetings
- Liaising with community mental health teams on admission and discharge

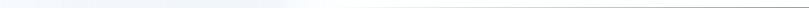
Important Knowledge / Skills

Psycho-Oncology focuses largely on communication skills, with both patients and colleagues. One crucial skill is feeling confident and competent in performing the Mental State Examination, which assesses a patient's appearance and behaviour, speech, emotion, perception, thought, insight and judgement, and cognition (think ASEPTIC!).

Common Conditions	Key Skills
Adjustment disorder – acute mental health condition often presenting with intense emotional reactions, caused by a major trigger such as a life-changing event (e.g. cancer diagnosis) Anxiety Depression – low mood, lack of energy, anhedonia Pre-existing mental health conditions: e.g. known depression or anxiety, bipolar disorder, OCD, personality disorder, PTSD, schizophrenia	Psychiatric history-taking Mental State Examination Letter writing for patients and GPs MDT working – presenting cases at board rounds and MDT meetings, liaising with ward teams and community mental health teams



Section 4



Exception Reporting

Dr. Oliver Brady

What is Exception Reporting?

Exception reporting is the mechanism by which resident doctors can report if their actual working day differs from their work schedule. It has an important role in identifying areas where conditions may be improved to protect safe working hours.

Examples of events to report include:

- Working additional hours beyond your schedule – e.g. having to stay late or arrive early to complete work
- Missing or reduced rest breaks – e.g. not being able to break during a shift due to work pressures
- Loss of training or educational opportunities – e.g. not being able to attend foundation teaching due to clinical pressures

A report should be submitted for each day where one of these events occurs.

What happens when I make an Exception Report?

If your report relates to working additional hours, your report will be reviewed by the medical workforce team. You may choose between receiving payment for the additional hours worked or Time off in lieu (TOIL).

Reports for over 2 additional hours will automatically trigger a review from the Guardian of Safe Working Hours (GOSH).

By reviewing exception reports, the medical workforce team and GOSH may identify patterns and themes of recurring problems. These will be escalated and may result in future adjustments to working patterns or changes to staffing levels. It is therefore important to always remember to report events, as it allows the trust to enact change and improve safe working hours.

If your report relates to missed educational opportunities, your report will also be reviewed by the Medical Education team.

How do I make an Exception Report?

Different trusts will have different platforms to submit a report. The trust is required to provide you with access to their reporting system within 7 days of starting your post.

You must submit your report within 28 days of the event, although try to submit a report as soon as you can after the event. This helps you remember the details and keeps on top of any admin building up.

The report should include details of

- The date of the exception,
- The nature of what happened,
- The duration of any additional hours worked
- Any supporting details such as what shift you were working (long day on call, night shift, normal working day etc..)

You may also need to provide geolocation data to verify your reports. An easy way of doing this is by screenshotting Maps on your phone, proving you were at your place of work until the time you say you had to work until.

Escalating Concerns

Dr. Christina Taaffe

How do I raise a Concern?

Working in healthcare may expose you to situations where you need to raise a concern. These may be around patient safety concerns, personal concerns or regarding your work schedule, rota and working conditions. There are multiple avenues to raising a concern, and it can be difficult to navigate when you are new to a Trust. The list is not exhaustive, and there may be other support networks within individual trusts, however the below should all be accessible within the North-West.

Personal Concerns

As a Foundation Doctor, you may face a situation where you need to speak with someone about something personal to you. This may be about you or your loved ones' health, your wellbeing, concerns involving colleagues or related to your working environment. Below is a list of ways to seek support and more details on ways they may offer to help.

Educational Supervisor

Your educational supervisor will be a point of contact for you throughout your foundation training. In the North-West this would typically be the same person for 2 years as you stay at the same trust. They are a point of contact for mentorship, monitoring your progress and ensuring you can meet the curriculum requirements. You are encouraged to discuss any concerns with them as soon as possible. They can work through any concerns you may have and help you to escalate these further if required.

Clinical Supervisor

Your clinical supervisor will be allocated for each 4-month rotation block. They are typically specialists working within that area, providing day-to-day placement supervision. They are the primary point of contact for you within that department for any patient safety, training or personal concerns you may have on your block. They can work through any concerns you may have and help you to escalate these further when required.

Foundation Programme Team

Your Foundation Programme department will have the Foundation Programme Director and Foundation Programme Administrators who can support you with any concerns you may have. They will be a good source of support for any educational concerns throughout your foundation years and will be able to direct you to other sources of support that you may require.

North-West Foundation Forum (NWFF)

The NWFF is an active foundation doctor group, comprising of Foundation Year 1 and 2 Representatives from each trust within the Deanery. They share best-practice and have a direct line to the School Director. Concerns can be raised to representatives who will be able to escalate concerns which have not been solved locally and direct these to the School Director when required.

Escalating Concerns

Dr. Christina Taaffe

Patient Safety & Dignity Concerns

Patient Safety

You have a professional duty to raise any concern which impacts or could impact patient safety. You are encouraged to try and deal with the concern immediately where possible and raise it with a senior colleague - whether that is your registrar or consultant. It is important to report what has happened through formal reporting methods such as an Incident Report/Datix. If you are having difficulty raising the concern, the Freedom to Speak Up Guardians are there to provide independent confidential support and advice. The GMC has a 'Raising and acting on concerns' flowchart which may be useful for reference. (1)

Dignity Concerns

If you or a colleague is facing dignity concerns such as bullying, discrimination, sexual harassment, exclusion, unfair treatment or inappropriate behaviours from colleagues and patients you will need to seek support. Your Educational and Clinical Supervisors may be able to support you, however the Freedom to Speak up Guardians will be a confidential, independent route for workers to raise these concerns. They help to foster an open, supportive culture, ensuring staff are empowered to speak up.

Working Conditions/Rota

Due to the rotational aspects of foundation training, it is possible you may face difficulties with your work schedule, rota, pay or face unsafe working conditions. There are multiple avenues to help you.

Work Schedule/Rota

- Human Resources may be able to help you with your concerns. You can check whether your work schedule and rota are compliant on the BMA's rota checker. (2)
- Discuss with your Educational and/or Clinical Supervisor to see if they can help support you.
- As a member of the BMA, you can seek support from them if you are having trouble with your work schedule, rota or working conditions. Your hospital will have local BMA representatives who can help to direct you to the right place.

Exception reporting

If you are having difficulty with your work schedule or rota and finding that you are leaving late, missing breaks, missing educational opportunities or concerns regarding the level of support on shift you can raise these via exception reporting.

Exception reporting reforms have been implemented across all employers in England (from February 2026). This has led to the below changes:

- Removed the need to have supervisor signs off
- Rolling fines for employers who do not onboard resident doctors to a working system within 7 days of starting work.
- Choice of time off in lieu or payment for all time worked above contracted hours.
- Window to submit an exception report has been extended to 28 days.

References:

https://www.gmc-uk.org/cdn/documents/raising-concerns-process-diagram-web-links_pdf-80487188.pdf (1)
<https://www.bma.org.uk/pay-and-contracts/working-hours/work-schedule/bma-rota-checker> (2)

Further reading:

<https://www.bma.org.uk/advice-and-support/complaints-and-concerns/raising-concerns-and-whistleblowing/raising-a-concern-guide-for-doctors>

Datix Reporting, for Resident Doctors

Dr. Naina (Mandeep) Singh & Dr. Benjamin Rouse

Introduction to Datix Reporting

Datix is the incident reporting system used across the National Health Service (NHS). It allows healthcare professionals to document patient safety incidents, near misses and concerns. Its purpose is to promote a culture of learning and continuous improvement, identify system failures and reduce working risks. This is essential for improving patient outcomes and delivery of care. Datix reporting is not intended to foster or perpetuate the 'blame game'.

All healthcare professionals, resident doctors included, have a professional duty to report incidents promptly and accurately. This aligns with expectations set by the General Medical Council (GMC) and supports nationwide patient safety guidance, outlined by governing bodies like NHS England.

Roles and Responsibilities as an FY1/2

As Foundation Year doctors, we are at the forefront of patient-centred care, therefore playing a crucial role in ensuring patient safety and contributing to a learning environment.

Resident Doctors have a duty of candour and professional integrity.

- You should be open, honest, and transparent with both patients and colleagues in an event where care goes wrong.
- You should NOT hide or conceal mistakes. Reporting incidents allows for reflection on improving patient care and implementing changes. Hiding mistakes can leave room for recurrence, negligence, and serious patient harm.

Commonly Reported Incidents	Examples
Medication Errors	Prescribing / administration errors including incorrect drug, dose, route, missed doses, timing.
Discharge Errors	Unclear discharge summaries with errors. Medication errors upon discharge. Inappropriate discharges
Delays in care	Delays in reviews/treatments/referrals or critical investigations which can impact patients.
Staffing Issues	Unsafe staffing levels, rota gaps, concerns surrounding skills.
Diagnostic Errors	Missed, delayed, or incorrect diagnosis which are due to a system failure or have the potential to cause harm.

Datix Reporting, for Resident Doctors

Dr. Naina (Mandeep) Singh & Dr. Benjamin Rouse

How to Datix?

You Should:

Submit a Datix Report for:

- Patient safety incidents (e.g. medication errors, delays in treatment)
- Near misses (e.g. events that could have caused serious harm to a patient).
- Systemic issues (e.g. staffing, lack of equipment, breakdowns in communication across the MDT)

Ensure reports are promptly completed.

- They should contain clear, factual, and objective information.
- Avoid assigning blame or mentioning names.

Immediately escalate critical concerns to a senior clinician

- Datix reporting should not be used as substitute for urgent clinical escalation or documentation in a patient record

Complete all mandatory training related to reporting incidents and familiarise yourself with your trust specific reporting website eg: Datix, RLADatix, Ulysses.

What I wish I had known before starting FY1.

1. If a DATIX report is made about an incident you are involved in, **do not fret!** You may be made aware of the incident and receive some feedback (this is not always the case). The focus this feedback is on learning from the mistake, not being punished.
1. Writing a reflection on how you have learned from the feedback on a DATIX report can be a brilliant way to demonstrate that you are engaging in quality improvement and upholding the values of a responsible employee. This can benefit your Horus e-portfolio and show personal development.
1. The name of the person writing a DATIX report will be kept confidential, only accessible to relevant staff who review the report. The report shouldn't be shared widely.
1. Datix reporting should not be used as a threatening device or tactic to pressure resident doctors to complete tasks in an unsafe manner. Please seek support from your Supervisors if you find that this is an occurring issue on your ward.

Finances as an FY1

Dr. Megan Hassall

Expected Salary

- Current annual basic salary for FY1 is £38,831 – this assumes 40 hours a week and no out of hours which may be the case for some specialties
- This equates to £2,291.76 monthly take home pay after pension, tax, national insurance and student loan.
- Student loan payment plan 2 is £77 a month at basic salary rate but you do not start paying this back until April of your FY1 year
- When working heavier on call rotas, your pay will reflect this and will vary amongst trusts and specialties. On average, a medical rota will be closer to £3000 take home pay and a surgical rota will be closer to £2700 take home pay monthly.
- Remember – your pay is calculated on your generic work schedule for each rotation, not your actual rota which can seem unfair if you are working an extra set of nights compared to your colleague but unfortunately this is how it is across the NHS.

Payslips and Deductions

Checking your payslip against your generic work schedule:

- To calculate pay for additional rostered hours: additional contracted hours x 4.34535 x hourly rate
- To calculate your night duty pay: average weekly hours attracting 37% enhancement x 4.34535 x hourly rate x 0.37
- To calculate your weekend pay: (weekend allowance percentage x basic pay) divided by 10
- Your tax code should be 1257L-Cumulative as long as you're not working a second job. You may be given the wrong tax code when you first start so check your tax code on your first payslip and contact HMRC if this is wrong.
- You can use the Mind the Bleep doctors pay calculator to help

Deductions:

- NHS Pension deduction is 9.8% of your basic salary (can opt out of this but see point below)
- National Insurance is 8% of anything over £1048.01
- Tax is 20% of the total taxable pay after pension over the amount of £1039.12
- Student loan payment plan 2 is £77 but check the govt student loan website to check which repayment plan you are on and it will tell you the amount deducted
- Other taxable monthly deductions include car parking permits, doctor's mess memberships etc.
- NHS contributes 23.7% of your salary into your pension on top of your individual contribution, if you choose to opt out then you will lose this contribution. Your pension is also deducted before tax so 9.8% feels more like 8%

Budgeting as an FY1

- Your salary will change every 4 months so use your basic pay for cost of living and then when you are working heavier on call rotas you will have more money for savings, spends or holidays!
- Arrange for all your bills to go out on the 28th of each month and put some money away into savings – then the rest is for you to enjoy for the month!
- I know we complain a lot about pay but you will have money to go on holidays, go to socials and do whatever you enjoy without being stressed!
- You can also pick up Locum shifts in specialties you have worked in for extra pay too!

Mental Health Support

Dr. Erin Stevenson

Being a doctor can be demanding and the pressures of the role can affect your mental health and wellbeing. If you're finding things difficult, know that you're not alone and that support is available. Reaching out for help is a sign of strength, not weakness. Here are some resources that may be helpful.

Emergency Support

If you feel that you are an immediate risk to yourself due to thoughts of suicide or self-harm help is available:



In an emergency call **999** or go to your nearest **A&E** department
The most important thing is to tell someone

General Mental Health Support

Support, advice and treatment is available for mental health problems



Make a GP appointment



Learn to practice mediation



Self-refer to talking therapies



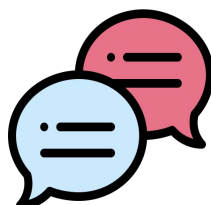
NHS Mental Health Resources

Mental Health Support for Doctors

Some of the mental health challenges faced by doctors are unique to our profession. There is support available specifically tailored to medical professionals:



BMA Support Line



Speak to your supervisor or a trusted colleague



Local occupational health resources



Additional BMA resources

Local trust handbooks

Dr. Khadija Ameir

University Hospitals of Liverpool



Blackpool



Northern Care Alliance



Glossary of Key Terms

ACP: advanced care practitioner. A healthcare professional with an additional masters, allowing them to practice at a higher level and with more autonomy.

AL: annual leave. 9 days per rotation, need to apply >6 weeks in advance. This doesn't roll over to the next rotation if not used up.

ARCP: Annual Review of Competence Progression. Happens at the end of May and is the annual review that all doctors in training go through, to ensure they have met the requirements to progress to the next year of training.

BMA: British Medical Association, the trade union for doctors. First port of call for contractual/ pay related issues

CBD: case based discussion, a supervised learning event. Case presentation and discussion with senior doctors (can only be signed off by SpR and above).

CCOT: critical care outreach team

CEPOD: emergency theatres, open 24 hours

CS: clinical supervisor

Datix: incident reporting system

DOPs: direct observation of procedural skills- a supervised learning event. Observed procedure (e.g. venepuncture, suturing).

ES: educational supervisor

Exception reporting: system used to report missed breaks, extra time worked, missed learning opportunities. Your supervisor has to respond to it and can optionally give you some TOIL or extra pay.

FDP: foundation programme director

GMC: General Medical Council, the regulatory body for doctors

Horus: the online platform used for the online portfolio in foundation years

List: usually relevant for on call shifts, "the list" is a list of newly admitted patients, their background, reason of admission and plan going forward. Usually kept up to date by the on call SHO.

LTFT: less than full time

MDT: multidisciplinary team

MDU: medical defence union, provides indemnity protection for doctors

Mini-cex: mini clinical evaluation exercise- a supervised learning event with an observed clinical interaction (e.g. history, examination).

MPS: medical protection society, provides indemnity protection for doctors

NEWS: new early warning score

NWFF: North West Foundation Forum. Made up of FY1 and FY2 reps.

Glossary of Key Terms

PA: physician associate

PALS: patient advice and liaison service. Deals with patient complaints.

PDP: personal development plan. Made by you on Horus for what you want to get out of each rotation and how you will achieve this. Mark it as achieved once done.

PL: professional leave. Not everyone is eligible for this, if you have an additional role that qualifies for PL you will be informed.

PSG: placement supervision group- survey to MDT about your competencies, organised by your clinical supervisor. Needs to include three people at minimum, one of whom must be a consultant. You need one satisfactory TAB a year.

RMO: resident medical officer (same as SHO)

SDT: self development time. Either 2 hours a week, a half day a fortnight, or a full day a month. Used for portfolio, professional development and work admin.

SHO: senior house officer

SL: study leave, ask the foundation team for the form, need to apply to your department >6 weeks in advance

SLE: supervised learning event (umbrella term for mini-cex, CBD, DOPS etc). Require feedback from a relevant senior clinician. Some can be signed off from FY2 doctors.

SpR: speciality registrar

Supernumerary: not included in minimum staffing figures, very supervised role. Usually for senior led specialities like paediatrics.

TAB: team assessment of behaviour- survey to the MDT about what you're like as a colleague (friendly/ professional/ punctual/ good team worker). You have to do one satisfactory TAB a year, and it needs to include minimum ten people. Try to do latter end of rotation 1.

Take: newly admitted patients under the on call team.

TOIL: time off in lieu. If you work a day on a bank holiday, you get a day of TOIL, which essentially an extra day of annual leave. You only gain the day of TOIL once you've worked the bank holiday shift. You can also get TOIL as the outcome of an exception report.

TTO: to take out- discharge medications

UKFPO: UK Foundation Programme Office