C.5 SUBMISSION TO IHRD ON GOVERNANCE FOR DOCTORS

1. The systems for supporting good medical care (as provided by doctors individually or as part of a clinical team) can be broken down into a number of areas as follows:

    1. GMC requirements for professional practice and revalidation
    2. Identifying and responding to poor practice
    3. Medical education and training
    4. Induction processes

2. For the first 40 years of the Health Service the accountability of doctors was to their patients and to a broad and non-specific professional code (The GMC's "blue book" – Professional Conduct and Discipline: Fitness to Practise - The final revision of which (GMC 1993.pdf 25416432.pdf) was superceded in October 1995 by the initial version of Good Medical Practice). To begin with the Health Service provided a setting where doctors could exercise their skills with almost complete autonomy.

3. In line with the development of trust status, the creation of the role of medical director in the early to mid 1990s sought to align the work of consultants more fully with that of the parent organisation [ME letter of 4/10/95 – HSS Trusts – Role of Executive Directors with professional qualifications – hard copy only]. All these changes have sought to support the historical duty of clinicians to continuously strive to develop professionally - to acquire and retain clinical skills, to access and use best evidence, to participate in planning for quality, and to evaluate and optimise processes of care. These new and explicit forms of accountability have been captured in the concept of clinical governance.

GMC requirements for professional practice and revalidation

4. The General Medical Council (GMC) is the regulator for doctors in the UK. It has four main statutory functions under The Medical Act 1983;

- Keeping an up to date register of qualified doctors
- Fostering good medical practice
- Promoting high standards of medical education and training; and
- Dealing firmly and fairly with doctors whose fitness to practise is in doubt.

Good Medical Practice and the Duties of a Doctor

5. The key document setting out the standards of medical practice for doctors is "Good Medical Practice". This has been reviewed and updated at regular intervals over the years with versions issued in 1995, 1998, 2001, 2006 and 2013. The links to the revision are included below:

- http://www.gmc-uk.org/good_medical_practice_oct_1995.pdf_25416576.pdf
- http://www.gmc-uk.org/good_medical_practice_july_1998.pdf_25416527.pdf
- http://www.gmc-uk.org/gmp_2001.pdf_25416526.pdf
- http://www.gmc-uk.org/Good_Medical_Practice___Archived.pdf_51772200.pdf
- http://www.gmc-uk.org/static/documents/content/GMP_2013.pdf_51447599.pdf

6. *Good Medical Practice* includes "The duties of a doctor registered with the General Medical Council". From the 2013 edition, these are set out under four domains;

- **Knowledge, skills and performance**
  - Make the care of your patient your first concern.
  - Provide a good standard of practice and care.
  - Keep your professional knowledge and skills up to date.
  - Recognise and work within the limits of your competence.

- **Safety and quality**
  - Take prompt action if you think that patient safety, dignity or comfort is being compromised.
  - Protect and promote the health of patients and the public.

- **Communication, partnership and teamwork**
  - Treat patients as individuals and respect their dignity.
  - Treat patients politely and considerately.
  - Respect patients' right to confidentiality.
  - Work in partnership with patients.
  - Listen to, and respond to, their concerns and preferences.
  - Give patients the information they want or need in a way they can understand.
  - Respect patients' right to reach decisions with you about their treatment and care.
  - Support patients in caring for themselves to improve and maintain their health.
  - Work with colleagues in the ways that best serve patients' interests.

- **Maintaining trust**
  - Be honest and open and act with integrity.
  - Never discriminate unfairly against patients or colleagues.
  - Never abuse your patients' trust in you or the public's trust in the profession.
  - You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Revalidation Timeline

7. Until the late 1990s, retention on the medical register relied solely on having obtained a suitable medical qualification and the GMC not having placed a sanction on a doctor's registration through their fitness to practice procedures. In February 1999, the GMC decided that retention on the medical register should rely on a doctor's regular demonstration of their fitness to practise. Thus the register would become a current record of fitness to practise, rather than a record of historic

qualifications. The GMC introduced the term revalidation for this process with a view to its implementation by 2001.

8. The 2001 public inquiry into the management of the care of children receiving cardiac surgery at the Bristol Royal Infirmary gave added impetus to the process as it exposed a number of issues relating to medical practice which resulted in harm to patients. These included poor supervisory arrangements, an absence of effective team working, absence of reflection on practice and assessment of competence and a lack of organisational and professional leadership.

9. The GMC then undertook to implement revalidation of its registrants by 2002. However the arrest of Dr Harold Shipman in 2001 and the subsequent Public Inquiries resulted in further delay as the issue of revalidation was considered during these inquiries. The DHSSPS responded to the Shipman Inquiry recommendations in the document Improving Patient Safety: Building Public Confidence in 2006. As part of its response to The Shipman inquiry The DH commissioned a review of medical regulation; Good Doctors, Safer Patients (2006).

10. This report was followed by the White paper, Trust, Assurance and Safety (2007) which set out a number of reforms to the regulatory arrangements for healthcare professionals, the aim of which were to restore patient and public confidence by ensuring the ongoing demonstration of fitness to practise.

Implementation of Medical Revalidation in NI

11. The DHSSPS responded to the 2007 White Paper Trust, Assurance and Safety (2007)by establishing the Confidence in Care Programme in 2008. A key element of the proposed regulatory reforms was the implementation of a system of revalidation for all healthcare professionals, commencing with medical practitioners.

12. From 2009, the Department, through the Confidence in Care Programme, commenced planning for the implementation of revalidation in NI, working in partnership with the GMC and the GB Health Departments. A comprehensive

stakeholder engagement programme for doctors, employers, patients and the public was delivered and underpinning policies and guidance were developed. A critical element of the revalidation model was the establishment and implementation of the Responsible Officer role. The Medical Profession (Responsible Officer) Regulations (Northern Ireland) came into operation on 1st October 2010. These Regulations established arrangements for the introduction of Responsible Officers (usually the Medical Director) in all designated HSC organisations and outlined their statutory duties in the evaluation of doctors' fitness to practise which include:

- Ensuring that doctors undertake regular appraisal;
- Establishing processes to identify concerns about a doctor's practise through regular review of organisational performance activity data;
- Ensuring that appropriate action is taken when concerns raised about a doctor's fitness to practise are identified;
- Referring concerns about a doctor to the GMC when appropriate;
- Maintaining records in respect of the above; and
- Making a revalidation recommendation on individual doctors' fitness to practise.

13. The commencement of the GMC's Licence to Practise and Revalidation Regulations on 3rd December 2012 allowed the regulator to commence revalidation. These Regulations require all medical practitioners to:

- Participate in an annual appraisal that considers all areas of their practice;
- relate to a Responsible Officer;
- Demonstrate during that appraisal that they are meeting the values and principles set out in the Good Medical Practice Framework (http://www.gmc-uk.org/guidance/good_medical_practice/contents.asp;
- Provide supporting information required by the GMC for revalidation including evidence of quality improvement activity, review of significant events and feedback from colleagues and patients for every revalidation cycle (5 years); and
- Participate in all of the above revalidation processes.

Benefits of Medical Revalidation

14. It is expected that all doctors will have revalidated for the first time by 2016. The Department is working with the GMC to develop a framework to demonstrate the value of revalidation to the regulator, employers, patients and the public. The anticipated benefits include:

- A consistent approach to the regular evaluation of doctors' fitness to practise;
- A clearly defined framework for appraisal and a statutory requirement for all doctors to participate in the process annually ;
- A statutory requirement to respond to concerns about a doctor's fitness to practise; and Promoting patient and service user involvement through the requirement to provide patient feedback at appraisal.

Local Processes to support the Quality of Medical Practice

15. It would be wrong to think that the processes for ensuring the quality of medical practice relied solely on the activities of the regulator. From the outset, it was clear that local processes, principally annual appraisal, would be a key element in the process of revalidation. Formal work on putting in place processes for the prevention and management of poor performance in doctors commenced in March 2000 http://www.dhsspsni.gov.uk/hss(md)_7-2001.pdf and resulted in the consultation document *Confidence in The Future* in October of that year. http://www.dhsspsni.gov.uk/confuture.pdf

16. In addition to recommending the introduction of a system of clinical governace, which would be taken forward through *Best Practice, Best Care* in April 2001, the report recommended the introduction of appraisal for all doctors across Northern Ireland. Formal guidance and agreed documentation for consultant medical staff was published in May 2001. http://www.dhsspsni.gov.uk/peu_11-01_consultants.pdf

17. Analagous documentation was published for GPs in 2002 http://www.dhsspsni.gov.uk/phcircularhss_md_30-2002.pdf, and non-consultant career grade doctors, clinical academics and public health doctors in 2003.

http://www.dhsspsni.gov.uk/peu_1-03_nccg.pdf

http://www.dhsspsni.gov.uk/peu_10-03_jas.pdf

http://www.dhsspsni.gov.uk/peu_9-03_phm.pdf

18. Whilst progress on revalidation was of a stop start nature throughout the 2000s, work on appraisal continued locally http://www.dhsspsni.gov.uk/hssmd14-05.pdf including an evaluation of the introduction of appraisal in Northern Ireland [hssmd23-05.pdf – actual report in hard copy only].

19. In addition, RQIA were commissioned to undertake reviews of appraisal processes in Trusts and General practice in 2008.

http://www.rqia.org.uk/cms_resources/RQIA%20Consultant%20appraisal%20report%20Sept%2008.pdf

http://www.rqia.org.uk/cms_resources/GP%20Appraisal%20Report%20Sept%2008.pdf

20. In the lead up to the commencement of revalidation in 2012, an assessment of readiness was completed for all HSC organisations [DH1/12/181907] which included an assessment of participation rates in appraisal and individual organisational support for the process.

21. Finally, when the initial elements of revalidation were finalised, revised appraisal documentation was developed and agreed to facilitate doctor's compliance with the requirements of revalidation. http://www.dhsspsni.gov.uk/hrd-hsc__tc8__1_2013_medical_appraisal.pdf

Identifying and responding to poor practice

22. The regulator is concerned with addressing the most serious examples of poor performance, those where a doctor's fitness to practise is in question. Employers have long standing processes in place to address concerns around a doctor's conduct or performance [DH1/07/17025]. For much of the period of relevance to the Inquiry, the circular on disciplinary procedures for hospital and community medical and dental staff (HSS (TC8) 15/91 applied (TRIM DH1/07/18416) which reflected the approach across the UK.

23. However, over the ensuing decade it became apparent that these procedures were limited in value, as they proved cumbersome and lengthy, with practitioners excluded from practice for prolonged periods pending conclusion of the process. Work in both Northern Ireland (Confidence in The Future) and England (Supporting doctors, protecting patients : Department of Health - Publications) were published with the aim of addressing perceived shortcomings of the extant procedures. The latter document stated "*opportunities to identify problems early, so that doctors can be helped by educational measures, are infrequently taken. Disciplinary solutions late in the day have been the more usual approach.* Confidence in The Future recommended "*The current disciplinary procedures be abolished and replaced by fairer, quicker and more effective local procedures which integrate processes involving the HPSS and professional bodies".*

24. In 2005, HSS (TC8) 6/2005 was issued. This introduced Maintaining High Professional Standards in the Modern HPSS – A framework for the handling of concerns about doctors and dentists employed in the HPSS. (TRIM DH1/07/19055)

25. In anticipation of the revised arrangements, DHSSPS entered into an agreement with the National Clinical Assessment Authority (NCAA) in November 2004. The aim of the arrangement was to support The HPSS in the appropriate management of doctors and dentists, including those in general practice, whose performance gave cause for concern. The NCAA provides advice on handling concerns about the performance of practitioners and assessment where the concern

about a practitioner is substantiated and significant, but not so serious that patient safety is seriously at risk where referral to the GMS or GDC is required. (TRIM DH1/07/19043).

26. In 2009, the DHSSPS issued HSS (MD) 21/2009 bringing attention to the issue of work-related mental ill health. http://www.dhsspsni.gov.uk/hss-md-21-2009.pdf

27. This highlighted the fact that ill health in a doctor needs to be considered by both occupational health and governance systems.

28. Either as a result of working through local processes or directly, referral may be made to The GMC. The GMC can take action if the doctor's fitness to practise is impaired. This may be for a number of reasons:

- Misconduct
- Poor performance
- A criminal conviction or caution in the UK (or elsewhere for an offence which would be a criminal offence if committed in the UK);
- Physical or mental ill-health;
- A determination (decision) by a regulatory body either in the UK or overseas.

29. If the GMC believes that a doctor's fitness to practise is impaired it can:

- Agree undertakings with the doctor
- Place conditions on their registration
- Suspend their registration
- Remove them from the medical register

Medical Education and Training

30. Explicit standards for all phases of medical education and assurance processes against those standards have evolved over the past two decades as has the infrastructure for the quality assurance and delivery of medical education.

Undergraduate education

31. Prior to 1993, when The GMC published its first edition of Tomorrow's doctor (gmc-uk.org/Tomorrows_Doctors_1993.pdf), there was no uniform curriculum for undergraduate medical education. Course content was largely at the discretion of individual university medical schools although subject to oversight and visitation by The GMC's Education Committee; established under statute for this purpose. There have been further editions of tomorrow's doctors periodically over the ensuing two decades.

gmc-uk.org/TomorrowsDoctors_2003.pdf

gmc-uk.org/TomorrowsDoctors_2009

32. The medical school at Queen's has three reports available for the period 1998 – 2013.

gmc- belfast_1998.pdf

gmc- Belfast_2005.pdf

gmc- Queens_School_of_Medicine.pdf

33. In 2007, The Department established The Safe and Effective Care Undergraduate and Postgraduate Group with the aim, amongst other things, of providing a forum to facilitate discussion and action with educators and training providers to improve patient/client safety. [DH1/09/158997] The forum has met at least annually thereafter to consider issues of patient safety that may be addressed, in part, through undergraduate and postgraduate education.

Postgraduate training

34. The regulation, oversight and quality assurance of postgraduate medical education has, as with undergraduate education, undergone significant evolution over the past twenty years. Whilst The GMC has had a statutory role of "Promoting high standards of medical education and training" throughout that period, how this is brought into effect has been subject to frequent change over the past two decades. gmc Development_of_the_Regulation_of_Postrgaduate_Medical_Education_and_Training_2009.doc_30377404.doc

35. All of these changes have been with a view to a postgraduate training system that is accountable, quality assured and produces doctors with the knowledge, skills and wider attributes that meet society's expectations in contributing to a high quality service.

36. As was the case for the undergraduate phase, in broad terms the developments in postgraduate training can be summarised as;

- Publication of clear standards for training;
- Development of defined curricula for training in each specialty
- Defined end-point for specialist training and its certification
- Regular assessment of progress.

37. Throughout the period in question (indeed since 1953), the initial year following graduation from medical school, the pre-registration year, was governed by standards set by The GMC (in The *New Doctor*), implemented by the University and assured through visitation by The GMC. The pre-registration year saw newly graduated doctors, provisionally registered with The GMC, take up a

succession of specified posts as employees of hospitals. They would rotate through a number of posts during the year and successful completion, as attested by their university, allowed them to gain full registration with The GMC and thus compete for entry into the further stages of medical training. This remained the position until the introduction of the Foundation programme in 2005.

38. The first significant reforms (often referred to as the Calman Reforms) saw the publication of *Hospital Doctors—Training for the Future* in 1993. These were mainly concerned with improving specialist hospital training, principally the latter years (higher specialist training) leading up to completion of training. This led to the introduction from 1996 of

- the specialist registrar grade,
- explicit curricula,
- annual assessments of progress, and
- a definitive end point to training, denoted by the Certificate of Completion of Specialist Training, awarded by the GMC. [DH1/07/18726]

39. August 2002 saw the publication of *Unfinished Business: proposals for reform of The SHO grade* Unfinished-Business.pdf. This document produced by The CMO for England set out proposals to address the remaining issues covering the period from full registration to entry to specialist training, drawing on arrangements arising from the Calman reforms. Following consultation across The UK, The four Health Departments published *Modernising Medical Careers* (MMC) in February 2003.

dh_4054233.pdf

40. This set out the broad direction of reform, notably the establishment of foundation programmes in the immediate period post graduation, greater standardisation of subsequent specialty training programmes and progress through training based on the acquisition of assessed competencies. A UK Strategy group, which included the DHSSPS, was established to oversee further development.

Following piloting, the detailed arrangements were published in April 2004, as *Modernising Medical Careers: The Next Steps.*

Modernising medical careers : the next steps

41. The first stage of reform saw the introduction, from August 2005 of 2-year foundation programmes. These subsumed the pre-registration year although doctors still had to meet the GMC's requirements for full registration after the first year of the programme. The second year consisted of a further series of placements which aimed at developing the trainee progressively until the point where they were ready to enter specialist or general practice training. To achieve this the Programme aimed to imbue trainees with basic practical skills and competencies in medicine and including:

- clinical skills;
- effective relationships with patients;
- high standards in clinical governance and safety;
- the use of evidence and data;
- communication, team working, multiprofessional practice, time management and decision making and
- an effective understanding of the different settings in which medicine is practised.

42. The Foundation programme curriculum was published in mid 2005, setting out competencies to be acquired in the first (F1) and second (F2) years after graduation together with the means by which competence would be assessed. Of particular relevance to the Inquiry is core competency 7; Acute Care which included prompt assessment of the acutely ill patient; identifying and responding to acutely abnormal physiology; where appropriate delivering a fluid challenge safely to an acutely ill patient; reassessing ill patients appropriately after initiation of treatment and

requesting senior or more experienced help when appropriate. Section 4 included a list of procedures that F1 trainee should be competent and confident to perform including "intravenous infusions including the prescription of fluid". [Foundation Programme – Operational Guide – Hard Copy only]

43. The next stage of the Modernising Medical Careers (MMC) programme of work saw the introduction of the reformed specialty training system in August 2007. This stage of reform was overshadowed by controversy surrounding the associated recruitment process which relied on a UK-wide web-based application system, The Medical Training Application Service. Widespread concern across the medical profession led to an independent review of the policy http://www.nhshistory.net/MMC.pdf and an investigation by The House of Commons Health Select Committee. cm200708/cmselect/cmhealth/25/25i.pdf

44. However, the key principles underpinning the reforms – curricula for each stage of training and progress based on assessed competencies have remained and evolved subsequently.

45. Throughout the period in question, responsibility for assuring the quality of postgraduate medical training across health and social care in Northern Ireland has lain with The Northern Ireland Medical and Dental Training Agency - NIMDTA (formerly The Northern Ireland Council for Postgraduate Medical and Dental Education).

46. NIMDTA was originally established in 1970 as the Northern Ireland Council for Postgraduate Medical Education. Following a Review of the Council in June 2002, it was reconstituted as a HPSS Special Agency with effect from 1 April 2004 – S.R. 2004 No 62 refers.

47. NIMDTA commissions, promotes and oversees postgraduate medical and dental education and training throughout Northern Ireland. Its role is to ensure the provision of a competent medical and dental workforce with the essential skills to meet the changing needs of the population and health and social care in Northern Ireland. NIMDTA organises and delivers the recruitment, selection and allocation of

doctors and dentists to foundation, core and specialty training programmes and assesses the performance of trainees through annual review and appraisal. It works in close partnership with local education providers (principally HSC trusts and GP practices) to ensure that the training and supervision of trainees support the delivery of high quality safe patient care.

48. As an Arms Length Body, NIMDTA is accountable to DHSSPS for the discharge of its functions as set out in its management statement and financial memorandum. nimdta.management_statement_and_financial_memorandum.pdf In addition, NIMDTA is accountable to the General Medical Council (GMC) for ensuring that the standards set by the GMC for medical training, educational structures and processes are achieved. The Postgraduate Medical Dean, as the 'Responsible Officer' for doctors in training, has a statutory role in making recommendations to the GMC to support the revalidation of trainee doctors.

Induction processes

49. Induction for staff starting at a new unit provide an opportunity to advise them of best practice, relate that best practice to local procedures, identify patient safety issues and to help integrate them effectively and quickly into the work of their unit. This is particularly true for trainee doctors who, as part of their training, change post relatively frequently (as frequently as every four months in the first Foundation year and at least annually).

50. Throughout the period in question, particular attention has been given to ensuring the significant transition from medical student to pre-registration doctor takes place in a way that is supportive and minimises risks to patient safety. An element of this, work shadowing, has been in place since the mid 1990s. Final year medical students shadow a pre-registration doctor to familiarise themselves with the nature of the role.

51. Induction programmes for newly qualified doctors were first formally mandated in 1994. [DH1/07/18672] In subsequent years the nature and duration of these programmes evolved in differing ways across trusts in Northern Ireland. At

the request of the DHSSPS, in 2006, a group led by the Medical Director of the then Green Park Trust reported on the induction processes across Northern Ireland. The recommendations from this report have shaped the induction processes since then:

- http://www.dhsspsni.gov.uk/covering_letter_-_report_on_induction_processes_for_medical_staff_in_the_hpss.pdf
- http://www.dhsspsni.gov.uk/report_on_induction_processes_for_medical_staff_in_the_hpss.pdf

52. The current training system includes a regional approach to the induction of newly qualified (F1) doctors, including a regional day run by the Northern Ireland Medical & Dental Training Agency (NIMDTA) and Trust delivered induction including shifts shadowing clinical activity. These are set out HSC(TC8) 4/2013 (http://www.nimdta.gov.uk/regional-guidance-foundation-programme-employment-induction/)

53. There is also induction for General Practice (GP) and specialty trainees as follows:.

- http://www.nimdta.gov.uk/download/general_practice/gp-trainees/GP%20Induction%20March%202013.pdf

- http://www.nimdta.gov.uk/download/specialty_training/01%20Info%20for%20new%20Core%20Specialty%20trainees%20-%20June2013.pdf

Summary of progress and plans for the future

1. Medical Revalidation is at an early stage of implementation and will be evaluated to determine its effectiveness and how it complements clinical and social care governance systems.
2. The processes for identifying and addressing concerns over doctors' performance is the subject to revision in light of experience and in response to the findings of The Dental Hospital Inquiry.

3. The structure of postgraduate training is the subject of a further review, Chaired by Professor David Greenaway Shape of Training | Home, which is expected to report by the end of October 2013.

Annex A

Documents to be provided to the Inquiry

NUMBER	TITLE
1	Submission to IHRD on Governance for Doctors.
2	General Medical Council – Professional Conduct and Discipline: Fitness to Practise.
3	METL 4 October 1995 – HSS Trusts – Role of Executive Directors with Professional Qualifications.
4	Good Medical Practice 1995.
5	Good Medical Practice – General Medical Council – Regulating Doctors – Ensuring Good Medical Practice.
6	Improving Patient Safety: Building Public Confidence
7	Good Doctors, safer patients
8	Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century.
9	Confidence in Care – Programme Initiation Document.
10	The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010.
11	The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012
12	The duties of a doctor registered with the General Medical Council.
13	HSS(MD) 7/00 – Clinical Governance, Clinical Performance and Revalidation.
14	Confidence in the Future for patients, and for doctors.
15	HSS(TC8) 11/01 – Consultant's Contract: Annual Appraisal for Consultants.
16	HSS(MD) 14-2005 – Update on Appraisal and Revalidation.
17	HSS(MD) 23/2005 – Evaluation of Medical Appraisal Systems in HPSS

	Organisations (Cover letter). Report included (from hard copy) – Review of Medical Appraisal in Northern Ireland – Dr Nick Naftalin OBE, FRCOG – Jan 2006.
18	RQIA - Review of Consultant Medical Appraisal across HSC Trusts.
19	Assessing readiness to commence revalidation in Northern Ireland
20	HSS(TC8) 1/2013 – Annual Appraisal for Consultants and Staff and Associate Specialist Medical Staff in HSC Trusts.
21	HSC(TC8) 3/75 – Disciplinary procedure in cases relating to Medical and Dental staff employed by Health and Social Services Boards.
22	HSC(TC8) 15/91 – Disciplinary procedures for Hospital and Community Medical and Dental staff.
23	HSC(TC8) 6/2005 – Maintaining High Professional Standards in the Modern HPSS – A framework for the handling of concerns about doctors and dentists employed in the HPSS.
24	HSS(TC8) 5/04 – National Clinical Assessment Authority
25	Tomorrow's Doctors – Recommendations on Undergraduate Medical Education – December 1993.
26	General Medical Council – Regulating Doctors – Ensuring Good Medical Practice – Queens University, Belfast.
27	Promotion of safe and effective care undergraduate & postgraduate group.
28	Development of the Regulation of Postgraduate Medical Education and Training
29	HSS(TC8) 3/97 – Implementing the reforms of Specialist Medical Training.
30	Unfinished Business – Proposals for reform of the Senior House Officer grade.
31	Modernising Medical Careers – The response of the four UK Health Ministers to the consultation on Unfinished Business: Proposals for reform of the Senior House Officer grade.
32	Modernising Medical Careers: the next steps.
33	Operational framework for foundation training
34	Management statement between The Department of Health, Social Services and Public Safety And Northern Ireland Medical and Dental

	Training Agency – April 2010.
35	HSS(TC8) 11/94 – Compulsory induction courses and changing the starting date for junior medical and dental staff in the hospital service.
36	Cover letter for Report on induction processes for medical staff in the HPSS.
37	Report on induction processes for medical staff in the HPSS.
38	HSC(TC8) 4/2013 – Regional guidance re Foundation Programme Employment Induction.