Postgraduate Medical Education and Training Board

Annual Report and Accounts 2009-10

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Foreword by the former Chairman

Although a foreword for a review of the year would usually refer only to the year just past, I feel it appropriate to look back further given our merger with the General Medical Council.

As Chairman since 2008, and a Board member since its inception in 2003, I am very proud of the steps that the Board took to bring together the medical specialties across the four nations. Our very existence as a standalone regulator placed increased focus on postgraduate training, and we built strong working relationships with the medical Royal Colleges and deaneries; this cooperation was crucial to our effectiveness. Recently, I was pleased to be able to give thanks in person to many of our postgraduate colleagues who attended a reception at the House of Lords to celebrate all that PMETB has achieved.

We hand over to the GMC published curricula for all 61 specialties and 34 sub-specialties, ensuring that doctors know what they need to do to successfully complete their UK training programme. Similarly, the Article 14 equivalence route to the Specialist Register clearly articulates what doctors who have not followed this prescribed path must do to have their skills recognised. Furthermore, we have established a robust quality assurance framework which collects the information to tell us if training is taking place as it should be in our hospitals and GP surgeries.

Although placed in statute for 1 April 2010, in reality the continuum of regulation in medical education and training began much earlier. Since the 2008 announcement of the merger, PMETB staff worked with their GMC colleagues to ensure a joined-up approach across all the activities.

This year in Scotland we piloted joint deanery visits with the GMC to assure the quality of the foundation programme and specialty training within one visit. This will allow a reduction in the administrative burden on the deaneries, and also provide information as to how best to develop such activities forward in the future.

The synergies between our *Generic Standards for Training*, and the recently published GMC *Tomorrow's Doctors* will also ensure a consistency of standards across medical regulation. Lord Naren Patel's review of the future of regulation considered other areas where such synergies can be found, and he has reported to both the PMETB Board and the GMC Council with his recommendations.

The merger of PMETB with the GMC is the correct course and I am entirely confident that it will continue to be both smooth and successful. As a member of the GMC's Postgraduate Board, and a doctor myself, I also personally look forward to working with a single regulator for all stages of a doctor's career. However, the Board, staff and stakeholders of PMETB should see the mechanics of this merger as a tribute to their combined expertise and be proud of the rich legacy from the last seven years that has travelled from Waterloo across to the GMC's offices in Euston Road.

Professor Stuart G Macpherson

Comment by the former Chief Executive

In the following pages recording the final year of PMETB you will find both an historical and more recent record of PMETB's achievements.

Significant though they are, they need to be brought to life by a fuller recognition of the contribution made by those who have worked to achieve so much, in an organisation whose origin was doubted in some quarters, but now finds its work embedded into the mainstream of medical regulatory life in the General Medical Council. In 2009/2010 particularly, their contributions were against the back-drop of an organisation which would cease to exist.

Those contributors fall most obviously into three groupings. The first is members of the Board, who have by their personal and collective contributions championed the cause for the regulation of postgraduate medical education, which is evidenced by their work in committees and other settings and which continued tirelessly till March 2010. Such has been the strength of their work and commitment that many have been able to continue a role in the General Medical Council setting, enhancing continuity.

The second grouping is those most obviously associated with the delivery of medical education, the Medical Royal Colleges and postgraduate deaneries -throughout the UK – who have supported PMETB's work. Sometimes this has been under formal contractual arrangements which for good reason are being carried forward into the General Medical Council. Indeed, much of PMETB's work, for example in certification, simply could not have been undertaken without college involvement.

The third is PMETB's staff and Directors. For 2009/2010 especially their activities were set in the context of 'organisational change', which inevitably, despite the General Medical Council's welcoming stance, meant that personal anxieties had to be managed alongside both day to day delivery and policy development. Directors and staff need a special thank-you.

Though I'm proud to have been associated with PMETB and operated under the title of Chief Executive my involvement in truth was to ensure a successful merger. I make no claim to any influence or impact on PMETB's achievements in the field of postgraduate education and training. But that narrowly focused role means that I must also -and gratefully- acknowledge two merger contributors:

One is the Department of Health. There was much to do of a formal kind, dealing with the crafting of legislation and its parliamentary progress, as well as business cases and associated paraphernalia. Reflecting on the many negotiations and formal requirements, perhaps 'grateful' is not quite the right word, but Department of Health colleagues will know of the essential part they played, and in management-speak 'on budget and on time'.

The other is the General Medical Council which through its two Chief Executives and team of Directors and Assistant Directors played, in my opinion, the single most important role. It took the time to understand PMETB's work and how it was done, and importantly, who did it. In consequence it decided to transfer the work content largely unchanged in a style that became known as 'lift and shift', though with the

prospect of change over time. Though obliged under the TUPE legislation to take PMETB's staff, it did so with great care, with many staff able to benefit immediately from improvements in terms and conditions, and all from the increased opportunities that the larger organisation can offer, as well as an improved working environment and with the aid of state-of-the-art information technology .

The merger began with a recommendation from Professor Sir John Tooke in 2008. I am pleased to have played a bit-part in the life of PMETB to help ensure that the recommendation was implemented.

That has been done, and I wish the General Medical Council every continued success.

Graham Smith
Former Chief Executive of PMETB

Major achievements and milestones

2005

- Postgraduate Medical Education and Training Board (PMETB) assumes its statutory powers. The Board implements:
  - Standards for Curricula
  - Principles for an Assessment System for Postgraduate Medical Training
  - New equivalence routes to the Specialist and GP Registers

2006

April

- PMETB's *Generic Standards for Training* published

May

- In co-operation with the Conference of Postgraduate Medical Deans (COPMeD), PMETB launches the first National Trainee Survey to gather perceptions of trainees across the UK of their training

December

- PMETB and GMC jointly approve curricula for the Foundation Programme

2007

March

- PMETB and GMC hold a seminar on credentialing with a wide range of stakeholders to explore this important issue

April

- The summary outcomes report of first National Survey of Trainee Doctors is published

May

- PMETB conference, entitled: *What Does the Future Hold? Preparing Doctors for Tomorrow* formally launches the *Future Doctors* review
- PMETB launches consultation on the *Quality Assurance Framework* for postgraduate medical education and training

June

- All specialties receive PMETB approval of their curricula. For the first time, all have detailed, published curricula

September

- PMETB's inaugural annual stakeholder conference is attended by 200 delegates at the Royal College of Obstetricians and Gynaecologists in London

November

- PMETB's first cycle of visits to all deaneries in the UK, which began in March 2006, is completed
- PMETB launches a series of seminars for doctors in training. These comprise five UK wide seminars (November 2007 – January 2008) as part of the Future Doctors review. The seminars are called: S*haping the Future of Postgraduate Medical Education and Training: The Trainee Perspective*

December

- PMETB publishes the Quality Framework for Postgraduate Medical Education and Training in the UK
- PMETB launches the second annual National Survey of Trainee Doctors in conjunction with COPMeD as part of the Quality Framework

2008

January

- The inaugural National Survey of Trainers is launched, as part of PMETB's Quality Framework commitments
- PMETB publishes *Principles for Deaneries* and *Standards for Trainers*
- PMETB publishes the online *Quality Framework Operational Guide*
- As part of the Future Doctors review, PMETB holds a seminar for patients and the public titled: *Training in Partnership: Shaping the Future of Postgraduate Medical Education and Training in the UK*

March

- Formal contracts with Medical Royal Colleges are agreed to cement the obligations of both parties in relation to certification and quality work

May

- PMETB's new surveys reporting tool is launched, providing access to all survey results online for the first time
- PMETB issues 1000th Certificate of Eligibility for Specialist Registration (CESR)

June

- PMETB publishes reports of the *Patients' Role in Healthcare* and the *Educating Tomorrow's Doctors* work streams of the *Future Doctors* review

July

- Revised *Generic Standards for Training* replace both the *Standards for Trainers* (January 2008) and the previous version of *Generic Standards for Training* (April 2006)
- PMETB publishes *Standards for Curricula and Assessment Systems*, to replace both the *Principles for an Assessment System for Postgraduate Medical Training* (September 2004) and *Standards for Curricula* (March 2005)
- PMETB publishes *Standards for Deaneries*, replacing the *Principles for Deaneries* (January 2008)
- Two national survey outcome reports are issued: the first for trainers and second for trainees

August

- PMETB issues 1000th Certificate of Eligibility for GP Registration (CEGPR)

November

- PMETB's first annual edition of *The State of Postgraduate Medical Education and Training* is published

December

- The third annual National Survey of Trainee Doctors is launched in partnership with COPMeD

2009

March

- The second annual National Survey of Trainers commences

May

- PMETB introduces the combined route to CESR/CEGPR for doctors appointed to PMETB-approved programmes above ST1 on the basis of other training and/or experience
- PMETB launches Certification Online, which enables electronic application for the CCT
- PMETB and Academy of Medical Royal Colleges (AoMRC) publish *Workplace Based Assessment (WPBA) – A Guide for Implementation*

June

- An 86 per cent response rate to the National Survey of Trainee Doctors makes it the most comprehensive collection of primary evidence from trainees ever

September

- The *Role of the Regulator Report* shows the outcomes from the work stream of the *Future Doctors* review

October

- PMETB publishes *Future Doctors - A statement on the future of postgraduate medical education and training,* setting out how the regulator can help meet the long term challenges in postgraduate medical education and training
- Two pilots in Scotland begin to explore how specialty, including GP training and Foundation Programme training can be quality assured using a single visit process
- Combined analysis report for the National Training Surveys 2010 is published

November

- PMETB and the GMC approve curricula and assessment systems for Foundation Programme training years 1 and 2
- PMETB publishes *Post-certification research 2008 - a comparison of employment outcomes by specialty and certificate type*

2010

January

- Consultation on the review of the Future Regulation of Medical Education and Training (Patel Review) launched with the GMC.
- Merger legislation is approved by Parliament
- PMETB's review report of Annual Review of Competence Progression is published

February

- Launch of the pilots of the fourth National Survey of Trainee Doctors and the third National Survey of Trainers.

April PMETB merges with the GMC

Certification: maintaining the standards of applications to the Specialist and GP Registers

Until merger PMETB had responsibility for approving doctors for eligibility for entry to the GP and Specialist Registers through its certification processes. Applications came from all UK trainee doctors completing their postgraduate training programmes as well as applicants from overseas or those who apply through equivalence of training, qualifications and experience. This section summarises our achievements in certification during the financial year 2009/10.

There are three main routes to the Specialist and GP registers which were administered by PMETB. Firstly, where a trainee has followed a curriculum and successfully completed a full education and training programme that was approved by PMETB, that doctor would apply for either a Certificate of Completion of Training (CCT) or a General Practitioner Certificate of Completion of Training (GPCCT). Where doctors have not followed a complete PMETB-approved programme, then they can apply to be assessed for a Certificate confirming Eligibility for Specialist Registration (CESR) or a Certificate confirming Eligibility for General Practice Registration (CEGPR).

CESR and CEGPR assessments, which continue post merger, look at the evidence an applicant provides on their training, qualifications and experience (which may be a combination of the three) and may have been undertaken in the UK and/or overseas. Applicants are then assessed for equivalence to CCT standards in their specialty. There are other CESR routes for doctors who have trained overseas in specialties in which the UK does not award a CCT and also a route for those who work purely in academic and research medicines. PMETB also awards subspecialty training certificates which can be included on the Specialist Register and other forms of certification for doctors who wish to undertake some training or have their UK training recognised in other EU member states.

Achievements during the reporting period 2009/10

During the period we received a steady stream of CESR applications each month, but for CCT and CEGPR applications there is a small peak as trainees finish their training programmes at the end of January to early February and a much bigger peak at the end of July, when the majority of postgraduate trainees come to the end of their specialty and GP training programmes. July 2009 saw PMETB issue approximately 400 decisions, more than in any previous month to date.

In total we issued 6,550 decisions during the reporting period, of which:

- 3,501 were CCTs;
- 1,956 were GPCCTs;
- 371 were sub-specialty certificates;
- 547 were decisions relating to CESR applications; and
- 175 were decisions relating to CEGPR applications.

Of the 547 CESR applications decided, PMETB approved 274, and rejected 273 applications. For CEGPR, 145 of them were approval decisions and only 30 were rejections.

Where an application was turned down we gave detailed reasons for this decision with recommendations for further training and evidence.

We also:

- Issued 114 CESR/CEGPR review decisions; and
- Submitted 570 CESR applications to the Colleges/Faculties for evaluation.

On average, 546 decisions were made every month.

Workshops and training events

As well as contributing to training sessions for College staff and their evaluators, and attendance at BMJ Careers Fairs, certification staff have run sessions and contributed to Q&A sessions at eight workshops undertaken jointly with the BMA across the UK during September, October and November 2009. These events were well received with excellent feedback on the small group work sessions which enabled attendees to discuss specific issues within their specialty fields with certification staff at various stages of the application process.

College and Faculty contracts

Following detailed negotiations new contracts between Medical Royal Colleges/Faculties and PMETB first came into effect in April 2008. Colleges and Faculties undertake certification evaluations and make recommendations to PMETB. The new contracts mean an increase in the funds paid to Colleges and Faculties to help them improve the turnaround time for making evaluations and recommendations on CESR and CEGPR applications to PMETB. The introduction of a penalty clause helped ensure that most Colleges submitted their recommendations to PMETB within the agreed timescales. This enabled significant improvement in PMETB's ability to meet the deadlines to issue a decision from receipt of a full application (including referees' structured reports).

The CESR - CEGPR Review

During the year a review of CESR - CEGPR processes was undertaken by a working group, led by PMETB Board member Dr Namita Kumar, and included representatives from the Academy of Medical Royal Colleges and the BMA. It was established to examine the existing processes and identify areas for improvement. Many of the changes were implemented as the review progressed and the working group completed its work in September 2009. Following the review the steps outlined below were taken:

- Revised processes now in place, with deadlines for applicants, referees, Colleges and PMETB;
- A new framework for assessment and evaluation of applications based on the General Medical Council (GMC) four domain model of Good Medical Practice (GMP) to be used for revalidation was put in place;
- The introduction of improved and more focused structured referee reports;
- A revised College evaluation and recommendation form based on the four GMP domain headings;
- An on-line "Which route am I eligible for" wizard which leads potential applicants to the guidance for the route appropriate for them;
- Revised sub-specialty application form and guidance – introduced April 2009;

- CESR/CEGPR combined application (CP) process – introduced April 2009 (see separate section below);
- A review of the application form and guidance for those applicants wishing to seek a review of PMETB's decision to not approve their application – introduced June 2009;
- A new single specialty application form and more detailed guidance for applicants – introduced May 2009;
- Generic and Specialty specific guidance restructured to follow the four GMP domain model – introduced specialty by specialty from September 2009; and
- Details of the reapplication process and reapplication form for doctors who have completed additional training having initially been turned down by PMETB – introduced February 2010.

CESR/CEGPR Combined Programme (CP) applications

A significant outcome from the CESR - CEGPR review was the introduction of a *Combined Programme* route for CESR/CEGPR applicants. These applicants were appointed to a training programme beyond the beginning of specialty training on the basis of experience, either in the UK or overseas, and not previous PMETB approved training.

This route was developed specifically for individuals who have been appointed via a system that includes College representation and open competition, against job descriptions and person specifications approved by Colleges. From entry to a training programme above year one, to its successful completion, these doctors will have been continually assessed and have available records of their progression through a programme including details of relevant College examinations taken and required assessments.

The review group determined that it would not be necessary for such doctors to go through a full CESR/CEGPR application process and that a more streamlined application process would be an appropriate and proportionate solution that was welcomed by Colleges, Faculties, postgraduate deans and doctors alike. This new application process was successfully introduced in April 2009.

Certification panels

PMETB's certification panels examined and made recommendations on applications submitted to PMETB for entry to the GMC's Specialist or GP Registers. Panels consider applications which are referred to them by the Certification Directorate. These can include applications where the recommendation made by the College/Faculty may be neither clear, appropriate nor satisfy the legal requirements or where the College has not undertaken an evaluation for whatever reason.

There were on average two certification panels per month which look at a number of cases as well as panels which look at specific specialties to monitor consistency of decision making. During 2009, Colleges were invited to send representatives from their own evaluators to observe PMETB panels.

Certification Online

Certification Online was the name of the new online CCT application system which went live in May 2009. This system replaced the previous paper-based process and

offered a number of benefits to applicants who are due to complete their approved (CCT) programme of training. These included:

- Peace of mind for trainees that their application had been received. The process checks an application is complete and correct with built in validations;
- Simplification of the CCT application process through a user-friendly system design, clear presentation and easily accessible help text;
- Secure online payment options and application process which had undergone rigorous testing;
- Allowing trainees to review the status of their application and update their personal details at their own convenience.

This online application system helped PMETB deal with applications more efficiently, particularly during the two peak periods (January and July-August). The volume of applications during these two peak periods, particularly July, had become much greater because of the appointment of trainees to the new specialty programmes from August 2007.

Certification statistics

Details of certification decisions were available on the PMETB's website and updated every quarter. The aim is to provide applicants with a greater insight into the extensive work done by the certification directorate since PMETB's inception in October 2003 and the success rates for each category. These have been arranged by specialty and are available for CESR, CEGPR and CCT applications.

Certification research

Between September 2005 and March 2008, PMETB had issued over 11,000 CCTs and given decisions to almost 2,400 doctors who have applied for either GP or specialist registration through the equivalence routes of Article 14 (CESR) or Article 11 (CEGPR). In mid-2008 PMETB commissioned research to understand what happened to these doctors in relation to:

- How their careers as successful applicants develop after certification?
- How quickly were applicants employed after they received a certificate from PMETB?
- Is one type of certificate more likely to lead to employment at consultant/GP level than another?
- Are the various certificates issued by PMETB still considered to be sufficient for consultant level?
- CESR and CEGPR applicants' experience of the application process; and
- Whether those who required top-up training or were asked to submit additional evidence were clear about what was required from them in the light of PMETB's decision letter.

A full report of this research was published in November 2009.

Quality: securing and maintaining standards in postgraduate medical education

The Quality directorate had responsibility for activities that ensure the Board secures and maintains standards, and improves the quality of postgraduate medical

education and training in the UK. The directorate did this by approving all training against published standards, testing education and training outcomes through visits, dealing with concerns and national training surveys; and considering this against relevant evidence. The Quality team also approved all curricula and associated assessment systems, posts (such as Academic Clinical Fellowships), all programmes and GP trainers.

Developments over the year

- The final stage of the European Working Time Directive and Regulations was implemented in July 2009 with an average maximum 48 hour week. PMETB monitored the impact on training as part of its Quality Framework. PMETB set up a European Working Time Regulation Panel to monitor this final stage. Chaired by David Haslam, the panel had wide stakeholder representation that took an active interest from a UK regulator perspective. The group continued after merger and plans to report to the GMC.

- PMETB approved standards for all trainers in September 2007; with a date for full compliance set at January 2010. The survey results and a wealth of other information confirmed to PMETB that recognition of the trainer role is crucial to the success of postgraduate medical education and training. Trainers, who for the purposes of the regulator are clinical and educational supervisors, need preparation, recognition and sufficient resources to do this role properly.

- There had been a lack of clarity on the processes for monitoring subspecialty training. To identify ways of resolving this, a Subspecialties Task and Finish group was set up, chaired by Dr Chris Clough. The report recommended some immediate changes to the approval processes which PMETB's Training Committee approved.

- PMETB was asked to lead on developmental work centred on credentialing. A Credentialing Steering Group was set up and chaired by Dr John Jenkins. A report went to the Board in March and was sent on to the Department of Health (England).

- Selection into specialty training has been a challenging and at times controversial area within specialist medical education and training. The Assessment Committee agreed to a Working Group on selection into specialty training, chaired by Professor Sir Neil Douglas. The report of the Group approved by the Committee was submitted to the Board in March.

PMETB's Quality Framework

The Quality Framework (QF) was formally launched in December 2007 and continues post merger. It comprises five elements (standards and approval, visits to deaneries, national surveys, evidence, and responses to concerns) which inform each other and present a comprehensive picture of the quality of postgraduate medical education and training at the deanery and local education provider (LEP) levels. The Framework identifies three levels of responsibility and accountability: the Board's to quality assure; the deaneries' to quality manage (QM); and the local education providers' to quality control (QC). The Medical Royal Colleges work with these bodies at all three levels.

PMETB hosted a series of workshops in May 2009 to explore the outcomes of QA, QM and QC in more detail. These workshops were well attended and had presentations from deaneries, colleges and LEPs on how they had used the outcomes from the QF. These workshops exemplified the focus of the QF on quality improvement and not simply assurance.

Standards

Approval of curricula and assessment systems

All Royal Medical Colleges, Colleges and Faculties submitted their curricula and assessment systems for a review against PMETB's standards for assessment and curriculum. This was the third and final stage of ensuring all 61 specialties and 34 subspecialties curricula and assessments meet the standards for assessment and curriculum. The review encompassed the 2009-2010 annual College summaries, and any major changes the Colleges wished to make. It was an important opportunity for both PMETB and the Colleges to consider the curricula and assessment systems after two full years of implementation.

Within their revised curricula and assessment systems, the Colleges were asked to also consider key developments such as the Medical Leadership Framework, greater patient involvement, and more explicit articulation of the skills, knowledge and attributes necessary for annual progression.

Approval of programmes, GP trainers and posts

In order to be eligible to receive a Certificate of Completion of Training (CCT) at the end of their postgraduate training, doctors must be able to demonstrate that they have followed an approved curriculum and assessment system in training posts and programmes approved by the regulator. Therefore, a major component of PMETB's quality assurance work was the approval of posts and programmes that directly contribute to the award of a CCT. PMETB approved over a thousand specialty programmes to be delivered by UK deaneries. Posts within these programmes are deemed approved and are not scrutinised separately by PMETB. However, new posts had to be separately approved and substantiated concerns may lead to a review of approval for specific posts.

During the reporting period, the approvals team considered 810 out of programme applications (referred to as posts). Of these, the Quality directorate approved:

- 635 out of programme training posts (OOPT)
- 162 out of programme research posts (OOPR) applications
- 9 acting up consultant posts

4 applications were not given approval. Typically these applications were either incomplete, lacked supporting evidence, or were seeking retrospective approval (which is not undertaken).

In addition, during the reporting period the Quality directorate received:

- 49 Academic Clinical Fellowship post applications
- 28 Clinical Lecturer post applications

To the point of merger PMETB had received over 2331 GP Trainer applications.

In addition to dealing with approval applications, the Quality team also published data on programme approvals, academic clinical fellowships and clinical lecturer approvals, and GP trainer approvals. The data, which was reconciled against deanery records, provides a complete picture of all of the approvals granted by PMETB.

National Surveys of Trainee Doctors and Trainers

The 2008/2009 surveys

The 2008/2009 survey activity heralded the most successful year ever, with an 85 percent response rate for the third trainee survey. The Surveys Reporting Tool worked well and significant work was undertaken to make the results more accessible. The tool, which included all of the results from the previous surveys, provided an invaluable snapshot of how trainers and trainees perceived the postgraduate training in which they were participating.

However the sheer volume and complexity of the information caused those using the reporting tool to find navigating their way through the information a challenging experience. Further work on simplifying the tool will be a priority for the GMC.

The Trainee Doctor Survey report noted that trainees' overall satisfaction with their training was high and had continued to improve since the first survey, evidencing the improvements being made to medical education and training. It also highlighted some areas of concern such as a perceived lack of time for training in some specialties, and with medical errors.

Amongst the key issues from PMETB's second Trainers Survey was a continuing significant difference in the preparation for training of GP Trainers and Consultants, with the former showing some very positive perceptions by comparison. The lack of time and resources to undertake trainer roles was a consistent message from the respondents.

The Trainer Survey provides PMETB with important insights into the effect of quality management and quality control on training and trainers. Not only does it give trainers the opportunity to give their views anonymously on the quality of the training that they provide, but it also gives the regulator an important insight into the structure, processes and support provided to trainers by LEPs, deaneries and other training institutions.

The survey results are available via the Surveys Reporting Tool available from the GMC's website www.gmc-uk.org.

Visits to deaneries

The purpose of PMETB's visits to deaneries is to assess deanery quality management processes and the local education provider quality control processes for best delivery of postgraduate medical education and training.

At the end of each visit a report is published which summarises the outcomes of the visit activity, assesses the deanery's quality management performance against PMETB's standards and requirements and so confirms continuing approval of training.

The following table summarises the visits to deaneries that were undertaken in the reporting period:

Deanery	*Visit date*
London Deanery	April 2009
KSS Deanery	May 2009
Wessex Deanery	June 2009
Wales Deanery	July 2009
East of England Deanery	September 2009
West Midlands	October 2009
East Midlands	November 2009
Pharmaceutical Medicine (thematic)	December 2009
Northern Ireland	January 2010

The visit to deanery reports can be found at: http://www.gmc-uk.org/education/postgraduate/visit_reports.asp

Evidence

There are three types of evidence:

- Evidence that is generated by PMETB such as the programme approvals or National Surveys;
- Evidence that is generated externally and passed directly to PMETB such as the Annual Deanery Reports and Annual Specialty Reports; and
- Indirect Evidence (not directly on training) that is generated externally and passed to PMETB. For example, as a signatory to the Concordats, PMETB accessed data and information from other co-signatory regulatory or inspection bodies

The National Surveys provide a strong indicator on the quality of medical education based on the perspectives of trainees and trainers.

PMETB built up a substantive body of evidence, strengthened with Annual Specialty Reports and the Annual Deanery Reports. The former provides for each specialty to inform PMETB as the regulator of key information, issues and strengths of the specialty training and to formally raise any concerns with PMETB (in addition to issues dealt with immediately). The deanery reports were required by PMETB in order for approval to be maintained and are succinct exception reports of progress on actions taken to enhance training and an action plan for the year ahead (the plans published by PMETB). A Learning Points report was published in July 2009 to provide an accessible summary of the key issues highlighted in the first year's reports and the recommendations for improvements to the reports in the second year. The standard for reports has greatly improved and PMETB as the regulator gained valuable quality metrics on UK PMET: both quantitative (ARCP data, national examinations data) and qualitative (exception reporting of concerns and notable practice).

The Quality team attended the Risk Summits coordinated by the Care Quality Commission in England, where they contributed to the development of a sector-wide sharing of evidence with clinical inspectorates or review bodies.

During the year PMETB continued to participate in the Wales Concordat processes contributing to the continuous development of a targeted and proportionate approach to regulation and information gathering. PMETB signed a Memorandum of Understanding with the Regulatory and Quality Improvement Authority of Northern

Ireland in 2008 and participated in a second review – this time blood transfusion services. PMETB worked with NHS Education Scotland and the NHS Quality Improvement Scotland to ensure appropriate evidence is available for the visits to Scotland in 2010.

Responses to concerns including triggered visits

The fifth element of the QF was PMETB's range of responses to concerns to ensure patient and/or trainee safety. Concerns can be raised at any level – from PMETB's own evidence, such as visit teams, by trainees or by external bodies or individuals. There will be a range of responses, including direct correspondence with deaneries, ongoing monitoring and, where necessary, triggered visits. The final sanction will normally be a withdrawal of approval for training, but the aim is to improve training wherever possible.

Anyone with a concern was asked to write to the Director of Quality at PMETB and now to the GMC. However, all local systems and procedures must normally have been followed first. The concern must be about postgraduate medical education and training and supported by evidence.

During the year one triggered visit occurred concerning training in an Accident and Emergency unit. Trainees were withdrawn from the night shift by the Postgraduate Dean on request of the PMETB. Approval was subject to conditions being met. All other concerns were dealt with locally.

Quality Assurance of Foundation Programme

Under the Quality Assurance of Foundation Programme (QAFP), the General Medical Council (responsible for Foundation Year One) and PMETB (responsible for Foundation Year Two) undertook joint QA visits against agreed standards. QAFP teams visited Northern Deanery, Severn Deanery, North Western Deanery and Oxford Deanery. Reports and action plans are published on the GMC's website.

In addition to the ongoing visit programme, PMETB, the General Medical Council (GMC), the Conference of Postgraduate Medical Deans (COPMeD) and the UK Foundation Programme Office (UKFPO) meet on a quarterly basis to discuss and coordinate activities in relation to the delivery and quality assurance of the Foundation Programme across the UK.

PMETB and GMC reviewed the Foundation Programme Curriculum and assessment system in late 2009. The submission was approved with conditions.

PMETB Policy and Communications

The policy and communications directorate had the responsibility for ensuring that PMETB explained its role, responsibilities and actions clearly and making informed regulatory choices based on a wide range of information and expert opinion drawn from an array of knowledgeable sources.

Policy

Future Doctors review: shaping the content and outcomes of postgraduate education and training

The three year policy project, aimed at ensuring that postgraduate training equips doctors with skills and knowledge required to practice as specialists and GPs in a changing health service, concluded during the reporting year.

The earlier work encompassed extensive evidence gathering and stakeholder engagement through four work streams. The combined evidence base and recommendations of the working groups, including the results from the *Role of the Regulator* (published in September 2009), were examined by the Board-led Policy Working Group. The review culminated in the publication by PMETB of *Future Doctors – A statement on the future of postgraduate medical education and training* in October 2009.

In seeking to inform the future development of medical education and regulation, the statement is strategic in its intent, covering a number of major and long-standing issues. It outlines the guiding principles and actions the regulator should take over the coming years.

The review of the Future Regulation of Medical Education and Training (Patel review)

With the GMC, PMETB supported the review of the arrangements for the regulation of medical education and training led by Lord Patel. The review aims to maximise the benefits presented by a single regulator across the medical education and training continuum, and will inform future policy developments by the GMC.

During the reporting year, Lord Patel with a small working group considered the information and views of stakeholders gathered during preliminary work undertaken in the latter part of 2008. The emerging ideas were then tested with a wider reference group of stakeholders in November 2009.

The draft report, which makes recommendations for the future regulation of medical education and training in the UK, was published for consultation in January 2010. The consultation informed the final report which was submitted to the GMC and PMETB at the end of March 2010.

Post-certification research – a comparison of employment outcomes by specialty and grade

The directorate led the analysis of the certification research project. The purpose was to understand the outcomes of the various routes to specialist or GP registration and certification processes themselves.

The report of the analysis was published in November 2009. It sets out how the careers of nearly 2000 respondents developed after they received a certification decision from PMETB, how quickly successful applicants obtained employment at substantive level, and how well prepared for the role they felt.

PMETB-Engage

Over the past year, PMETB continued to build on the foundations established in 2008/09, and utilise and broaden the trainee, service and patient contact networks. These allow us to test PMETB proposals, gauge opinion and develop thinking, to ensure our work is relevant and helpful to all those directly affected by our policies and processes. PMETB-Engage launched at the end of March 2009 to further this aim.

This branded initiative assisted with electronic networking and consultation. Via our website, it invited anyone with an interest in postgraduate medical education and

training to register their contact information and area of interest. It attracted over 200 registrants.

Communications

The Communications team managed PMETB's communication channels including the intranet, website, events and PMETB updates and publications.

The team worked closely with the Quality and Certification directorates to support key projects including:

- Partners' Conference
- Future Doctors Policy Statement
- National Training Surveys 2010

State of Postgraduate Medical Education and Training

The second edition of *The State of Postgraduate Medical Education and Training* provided an annual review for the postgraduate medical education and training (PMET) sector. The publication brings together data, comments and opinions from the sector to make sense of the diversity and complexity of contemporary PMET. The 2009 edition featured comments from a wide variety of contributors from the sector covering topics such as medical leadership, different perspectives on assessment and curricula, quality management and professional development and the future of PMET regulation.

Since its launch in November 2009, over 2,000 copies of the document where downloaded and 1,000 hard copies distributed.

PMETB's National Stakeholder Conference 2009

PMETB's third annual stakeholder conference drew a full house. More than 200 people attended the event, held on 1 October at Royal Institute of British Architects in London.

Delegates attended a series of plenary presentations, including an international keynote session from Dr Thomas Nasca on the differences between the US and UK systems of postgraduate medical education regulation and an update on *Developing the Wise Doctor* from surgeon, educator and author, Mrs Linda DeCossart. Afternoon workshops discussed quality, revalidation and PMETB's *Future Doctors* policy work.

The event saw the launch of three important publications on the day. These were the *Future Doctors Policy Statement*, the *National Training Surveys 2008/09* and *SoPMET2009*

Partners programme

Introduction

PMETB Partners were recruited between October 2007 and February 2008 in order to support the Certification and Quality directorates in their work. Since that time, they participated in nearly 200 panels and visits. At the point of merger the group was formed of:

- 201 specialist doctors covering 52 medical and surgical specialties;
- 95 lay professionals with a wide range of non-medical expertise; and
- 42 medical trainees from all levels of specialty (including GP) training.

Partner activity

Partners participate as panel members in the following:

Certification panels	General panels Specialty specific panels Sampling panels (quality assuring past decisions)
Quality panels	Sub-specialty approval panels Curriculum and assessment approval panels Post and programme approval panels Visit to deanery panels Formal review panels

Visits to deaneries (including triggered visits)

The year saw a high level of activity, with a total of 523 opportunities for partners to participate:

	2008/2009	2009/2010	Partners involved in each
Certification panels	27	25	7
Visits to deaneries	6	10	7
Quality panels	36	52	5
Specialist input	13	18	1
Total	82	105	

How partners were trained

All PMETB Partners received general training, followed by specific training in specific panel work. The general training covered PMETB's legal responsibilities, standards and principals, whilst training in specific areas of responsibility covered the activities themselves.

PMETB held a total of 24 training sessions over seven full days in London and Birmingham.

Some experienced Partners have also been given the opportunity to participate in further training to become Lead Visitors and Lead Partners:

- Lead Visitors took responsibility for leading visits to deanery teams and ensuring these significant undertakings were carried out successfully. They where trained individually by shadowing a Lead Visitor on two visits to deaneries.
- Lead Partners where newly formed group of Partners recruited to chair panels post merger. They will augment the group of board members who have agreed to continue their involvement with the Partners programme. They were trained in two full day workshops in January 2010.

Number of Partners trained in different areas of PMETB activity

	Lay	Specialty	Trainee
General	95	201	42
Certification panels	75	127	Not applicable
Visits	82	151	34
Quality panels	91	150	32

PMETB Partners' Conference 2010

On the 24 February 2010, 94 Partners attended the second annual Partners' Conference, held at the Holborn Bars in London. Partners participated in discussions around the merger with the GMC and the development of Quality panel work. There were also talks on the future of postgraduate work at the GMC and the impact of European Working Time Regulation on education and training. The outcomes from discussions will inform Partner developments in 2010/2011.

Developments during 2009/10

- Partners' website – in June 2009 a new section of the PMETB website was launched. It contained information for members of the public and stakeholders on the role of Partners as well news and resources for Partners themselves.
- Performance review – in September 2009 a review process was introduced to monitor performance in panels and visits. The process was introduced following a pilot run and extensive consultation with the Partners.
- Continuous professional development (CPD) certificates – now issued annually to confirm participation in Partner activities.

Appeals: review of reporting period

Appeals against PMETB decisions, acts or omissions

The Office of the Directorate of Appeals adjudicated on appeals on behalf of PMETB. This was a formal independent statutory process and appeals could only be made under seven legally defined grounds. These are where PMETB:

1. failed to give a decision within three months of receipt of a complete application from an eligible specialist or general practitioner (GP);

2. failed to give a decision within four months of receipt of a complete application from an eligible general systems specialist or GP;
3. refused to award or withdraws a CCT;
4. was not satisfied that a general systems specialist or general systems general practitioner is eligible for entry to the GP Register or the Specialist Register under the relevant provisions of the Order or requires they complete an adaptation period;
5. was not satisfied that a specialist or general practitioner is eligible for entry to the GP Register or the Specialist Register under the relevant provisions of the Order or requires they complete additional training, examination(s) or assessment;
6. refused to award a GP a certificate of acquired rights to practice; and
7. imposed conditions on, refused or withdrew approval from a hospital, training institution or trainer.

The Office of the Director of Appeals made all administrative arrangements for appeals, provided impartial day-to-day support to the parties, and acted as a link between the Director of Appeals, the appeals panel, and the parties to the appeal (the appellant and PMETB as the respondent). Appeal panels consisted of a legally qualified chairman who is a solicitor or barrister, a lay member and two medical members (from different specialties and one of whom may be from the same specialty as the appellant).
During the reporting period, 16 new appeals against PMETB decisions were received and independent appeal panels heard 9 appeals. Of these, 14 appeals were under ground 5 and 2 were under ground 1.

- Both appeals under ground 1 were withdrawn as they received their decision during the appeals process so did not reach the hearing stage.

Of the 9 appeals heard against PMETB decisions under ground 5:

- 5 appeals were allowed in favour of the appellant i.e. PMETB's decision on the application was overturned;
- 3 appeals were dismissed and PMETB's decision was upheld;
- 1 of these had the conditions and requirements for the appellant's further training modified;

Other information

PMETB governance and our senior management team

PMETB was established and governed by the *General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003* (the Order). The order remained in force until merger with the GMC on 31 March 2010. Through the Order a formally recognised Board and two statutory committees where established with responsibility for ensuring that the organisation exercised its functions appropriately.

The Board

The Board had a membership of 25: 17 medical members and eight lay members. Appointments where made via the independent Appointments Commission, which makes recommendations to the Secretary of State.

There where also four observers from the four UK Health Departments (the Department of Health; the Scottish Executive Health Department; the Department of Health, Social Services and Public Safety, Northern Ireland; and the National Assembly for Wales). The observers are invited to contribute fully at Board meetings but cannot vote.

Details of the Board members who served during the reporting period can be found in Annex 1.

The statutory committees

The Training Committee develops standards for training, curricula and entry to specialist training. It promotes improvements to the quality of training and develops policy for the quality assurance of postgraduate medical education and training.

The Assessment Committee is responsible for the assessment of those who apply to the Specialist and GP registers through the equivalence route, assessments carried out during training (including standards for examinations accepted as evidence for entry to, progress through and exit from, training) and certification at the completion of training.

PMETB senior management team up to 31 March 2010

Graham Smith, Chief Executive

Graham took up post in September 2009. He joined the organisation with a wealth of experience from a variety of senior Department of Health and National Health Service positions, most recently as Chief Operating Officer for Modernising Medical Careers at the Department of Health during 2008, later in 2008 and into early 2009 he was Chief Executive and Registrar of the Nursing and Midwifery Council.

Lesley Hawksworth, Director of Certification.

Lesley led PMETB's work on certification of doctors to the GP and specialist registers. After starting her career at the Department of Health, including policy responsibility for medical education and regulation, Lesley established and worked at the Specialist Training Authority (STA). Lesley was awarded an Honorary Fellowship of the Royal College of Paediatrics and Child Health in recognition of her contribution to medical education and training.

Patricia Le Rolland, Director of Quality.

Patricia Le Rolland has worked in the public sector for more than 30 years. She joined PMETB in September 2006 from the Quality Assurance Agency for Higher Education (QAA). Patricia worked in the NHS for several years prior to joining the higher education sector. Patricia then became a senior academic, working with colleagues across the university and local communities.

Luke Bruce, Director of Policy and Communications.

Luke joined PMETB in March 2006 after eight years working in policy roles in Westminster. Luke led the Policy and Communications directorate at PMETB.

Paula Harris, Director of Finance and Resources.

Paula Harris led the Finance and Resources directorate at PMETB. She joined PMETB in October 2008, following appointments at the Commission for Architecture and the Built Environment (CABE).

Equality work

During the reporting year, PMETB revised its Equality Scheme and related action plan to reflect current legislation, set out its intended actions and to restate the Board's commitment that equality and diversity would be embedded in all PMETB policies and operations. The related action plan included provisions to make use of the information gathered through PMETB's quality framework, for example analysing annual deanery reports to assess how deaneries implement the standards for training in relation to equality and diversity. The Scheme sets out how PMETB will meet its duties under race, gender and disability legislation, as well as the commitment to promote equality in the areas of age, religion or belief and sexual orientation.

PMETB continued to monitor certification applications outcomes across all six strands of diversity. This goes beyond PMETB's legal responsibilities as a public body. The data for 2009/10 is available below at annex 1.

PMETB also commissioned the second external equality impact assessment (EqIA) of its certification processes, which was completed in March 2010. The aim of this EqIA is to ensure that certification processes, procedures and related documentation are clear and accessible and that recent changes have had a positive impact for all applicants. The conclusions and recommendations have been passed to the GMC for consideration post-merger.

The quality framework also continued to monitor compliance with the equality and diversity elements of the standards for training. Analysis of deanery reports reveals that the majority of deaneries are compliant with these standards or have clear plans to become compliant in the near future.

In preparation for the merger of PMETB with the GMC on 1 April 2010, representatives from both organisations worked together to share experience, best practice and agree consolidated action plans and processes. This was a fruitful exercise and confirmed that both organisations have similar issues and challenges around equality and diversity. Work has focused on five key areas: merging both organisation's equality schemes and action plans; external engagement*;* equality impact assessments: reasonable adjustments and the collection and monitoring of diversity data.

Management commentary

Description of business, objectives and strategy

The Postgraduate Medical Education and Training Board (PMETB) was abolished on 31st March 2010 by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010.

PMETB was established as a body corporate by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (the Order) as an executive Non Departmental Public Body sponsored by the Department of Health and was managed by a Board and two statutory committees.

On 1 April 2010 the staff, duties, assets and liabilities of PMETB were transferred to the General Medical Council (GMC) or to the Department of Health (DH).

PMETB's Board comprised 25 members, made up of 17 medical, and eight lay members. There were also four Department of Health representatives who were eligible to attend meetings and were treated as members but who did not have the right to vote. Appointments were made via the independent NHS Appointments Commission, which makes recommendations to the Secretary of State. Under the provisions of PMETB's constitutional statutory instrument one member was nominated by the General Medical Council and six medical members were nominated by a body that represents Medical Royal Colleges in the UK.

PMETB's principal role was to:-

- Establish standards of, and requirements relating to, postgraduate medical education and training;

- Secure the maintenance of the standards and requirements established; and

- Develop and promote postgraduate medical education and training in the United Kingdom.

In exercising its functions PMETB's main objectives were

- To safeguard the health and well-being of persons using or needing the services of general practitioners or specialists

- To ensure that the needs of persons undertaking postgraduate medical education and training in each of the countries of the United Kingdom are met by the standards established, and to have proper regard to the differing considerations applying to the different groups of persons to whom the Order applies; and

- To ensure that the needs of employers and those engaging the services of general practitioners and specialists within the National Health Service are met by the standards established

The merger with the GMC dominated a great deal of the work towards the end of the 2009/2010 financial year, however PMETB continued during the year to perform work that was largely developmental as it retained its statutory responsibility for Postgraduate Medical Education (PME) until the merger was implemented.

If the merged organisation is to be successful it was important that PMETB continued to operate effectively as an independent statutory body. Setting aside the implementation of the merger the main themes for the work in 2009/2010 were:

The consolidation of core certification work, including
work to enhance customer service by providing the ability to apply online;

the implementation of new routes to attainment of a CESR following the CESR review in 2008/09.

The second full year of implementation of the Quality Framework where the focus was on:
triangulating evidence from different sources to support our quality assurance work;
reviewing curricula and assessment frameworks.

The completion of the policy work on *Future Doctors* and considering the implications of this for the content, outcomes and structure of PME.

Alongside this, with the publication of the *Next Stage Review* in England and the merger PMETB played a significant role in the development and implementation of policy in the wider PME/regulatory environment through potential work on credentialing and its implications for the structure of PME going forward, supporting the GMC in its own consideration of recertification and our contribution to the Patel Review which will influence medical education beyond the merger.

Performance against Targets 2009/10

What we said we would do	**Performance**
Work to enhance customer service by providing CCT applicants with the ability to apply online	The Online Certification Database went live in May and now accounts for approximately 90% of CCT applications
Implementation of new routes to attainment of a CESR following the review in 2008/09	The Combined Route application was successfully introduced during the year and approximately 80 applications were processed.
Triangulate evidence from different sources to support our quality assurance work	Accurate evidence successfully collected and collated from a number of sources used to effectively inform the QF activities.
Completion of policy work on Future Doctors as well as considering the implications	We published a widely understood and well received statement of policy which sought to balance the needs of our stakeholders.
Ensure PMETB is playing a significant role in the development and implementation of policy in the wider PME/regulatory environment through potential work on modular credentialing and its implications for the structure of PME going forward	A highly successful shareholder conference and PMETB is seen as supporting and assisting the profession and as leading and promoting PMET. PMETB has worked closely with DH and GMC on a working party to progress the work on credentialing.
Contribution to the Patel Review which will influence medical education beyond the merger.	PMETB contribution has ensured that there was a comprehensive review by Lord Patel of the regulation of Medical Education.
Supporting the GMC in its own consideration of recertification	We worked well with the GMC and liaised and fed expertise of Certification and of dealing with Royal Colleges and Doctors into the process

Equality, Policy and Employee Relations and Communications

PMETB continued to actively promote diversity and equality of opportunity within its workforce and had a policy of Equal Opportunities aimed to create and sustain a working environment that was fair to all. Through commitment, action and review, the aim was to ensure that employment, training and development opportunities were appropriate to the abilities of the individual regardless of their sex, race, colour, nationality, ethnic or national origins, disability, religion, age, marital status, working pattern, sexual orientation or gender reassignment.

In March 2010, the gender profile of our permanent staff was 18 male (27%) and 48 female (73%), with 95% (63 staff) working full time and 5% (3 staff) working part time.

The Joint Employee Forum (JEF) was a staff forum which acted as a means of consulting and communicating with staff on matters affecting the staff body. JEF was made up of five representatives from the different staff grades within PMETB and was chaired by the Director of Finance and Resources. The Forum was used as the negotiation body with staff over staffing issues relating to the merger with the GMC.

In addition to existing training provision, PMETB had an Individual Development Scheme (IDS) as part of the Learning and Development Programme. 56% (37 employees) participated in the scheme during the year and undertook a range of activities to aid their development.

Personal data related incidents

PMETB has worked with their Internal Auditors, South Coast Audit, to identify and manage information risks and introduced steps in the year to identify and address any weaknesses and to protect any personal data held.

Open Government

Under the Open Government code, PMETB did not charge fees for requested information, unless provision of the information would consume a significant amount of staff time and resources. No requests have been refused to the year ended 31 March 2010.

Political and Charitable Gifts

PMETB made no political or charitable gifts during the year.

Resources and Financial Position

In its role as an independent regulator responsible for postgraduate medical education and training, PMETB had a business model which provides for a progressive increase in fees for both types of equivalence application and Certificate of Completion of Training (CCT). The model was developed based on the intention that PMETB will not require Department of Health funding by the financial year 2009/10. The announcement of the proposed merger of PMETB with the GMC resulted in changes to this model as it was felt that it would not be appropriate to make the adjustments to the fee structure necessary to achieve financial independence.

The accounts to March 2010, prepared in accordance with International Financial Reporting Standards as applicable to the public sector context, show net operating costs after interest receivable of £ 2,253,165 (2008/09 £2,106,803). The Board was financed by grant in aid income from the Department of Health (DH) of £1,790,258 (2008/09 £1,425,000) of which £304,334 was merger related funding. Funding from

DH is received to meet cash flows associated with expected short term liabilities for capital and operating expenditure. Of the grant income received £6,900 was used to acquire tangible fixed assets. The remaining grant of £1,783,358 was used to cover revenue expenditure.

In 2009/10 income from fees amounted to £5,249,330 (2008/09 £5,172,827). Total expenditure for the year was £7,502,990 (2008/09 £7,318,885).

The main changes in expenditure from the previous year were as follows:

Increases in costs due to:

- Merger activities;
- The impairment of intangible non-current assets (QFIT);
- Depreciation of plant and equipment considered to have no useful economic life after the merger;
- Provision for tax due on Board members' expenses;
- Further implementation of the Quality Assurance Framework; and
- The cost of providing run-off insurance to indemnify the Board members of PMETB.

Reductions in expenditure, compared to 2009, occurred because:

- In 2009 additional one-off costs were incurred recruiting and training PMETB's Partners;
- The number of applications referred to the Medical Royal Colleges was lower in 2010; and
- The number of staff was lower in 2010.

At the end of the year reserves stood at £964,775, a decrease of £421,759 from the position reported at the end of the previous year. This decrease was planned in order to utilise grant funding received from the Department of Health in previous years.

The Board incurred expenditure on non-current assets (plant and equipment) of £6,900 (2008/09 £41,582 for plant and equipment, and £155,073 for intangible assets).

Creditor Payment Policy

PMETB observed The Confederation of British Industry's code of practice that all matured and properly authorised invoices should be paid in accordance with the terms of contracts or within 30 days. In addition, Government regulations required that during the current financial crisis small and medium enterprises should be paid within 10 days. At 31 March 2010 the percentage of invoices paid within 30 days was 99%, of which 70% were paid within 10 days.

Register of Interests

A register of members' interests was maintained and held at Hercules House, Hercules Road, London SE1 7DU. The register was available for inspection during office hours (9am to 5pm), or a copy could have been requested by post, fax or email. The register is now held by the General Medical Council.

External audit arrangements

The Board's external audit arrangements were established by The General and Specialist Medical Practice (Education, Training and Qualification) Order 2003.

Article 29(2) of the Order requires that:

"The annual accounts shall be audited by persons whom the Board appoints."

And Article 29(3) states that:

> *"No person may be appointed as an auditor under paragraph (2) unless he is eligible for appointment as a company auditor under section 25 of the Companies Act 1989… or Article 28 of the Companies (Northern Ireland) Order 1990."*

PMETB has re-appointed Baker Tilly UK Audit LLP as its external auditors.

In addition, Article 29(5) states:

> *"The Comptroller and Auditor General shall examine, certify and report on the annual accounts."*

Neither the Comptroller and Auditor General nor Baker Tilly UK Audit LLP undertook any non-audit work during the year.

Non Audit Services

During the year Baker Tilly Tax and Accounting Ltd, an entity related to Baker Tilly UK Audit LLP, performed additional services for the Board. Training on IFRS was provided to the staff of the organisation while Board members were provided with refresher training on the responsibilities of an Audit Committee.

Disclosure of information to the auditors

So far as the Department of Health is aware:

- There is no relevant audit information or internal control issues of which the auditors are unaware.
- All steps that ought to have been taken were taken to make themselves aware of any relevant audit information and to establish that the entity's auditors were aware of that information.

Going Concern

In February 2008, the Government announced that PMETB would merge with the GMC in April 2010. This followed a recommendation from Professor Sir John Tooke's inquiry into 'Modernising Medical Careers' to deliver a more seamless and consistent approach to the regulation of medical education and training at all stages of a doctor's career. Legislation to effect this was passed by Parliament in January 2010.

On 1 April 2010 the staff, duties, assets and liabilities of PMETB were transferred to the General Medical Council (GMC) or to the Department of Health (DH).

Remuneration Report

The Remuneration Sub-Committee of the Resources Committee ensured that PMETB had remuneration policies that were fit for purpose and applied consistently. The members of the Remuneration Committee comprised the following Board Members: Jane Reynolds, Ian Cumming, Trevor Pickersgill and John Smith.

The policy on termination of contracts is determined by the level of responsibility of the position. There is a notice period of one month for general staff, three or six months for senior staff and six months for the Chief Executive. Contracts are offered on a permanent basis, subject to certain requirements being met and successful completion of a probationary period. Contracts are occasionally offered on a fixed-term basis, generally to reflect the nature, and context of, the work involved.

Senior Managers' contracts

Name	Title	Date of Contract	Unexpired Term	Notice Period
Paul Streets (resigned on 31 August 2009)	Chief Executive	24.01.05	Permanent Contract	6 months
Paula Harris	Director of Finance and Resources	06.10.08	Fixed contract expires 30.06.10*	3 months
Lesley Hawksworth	Director of Certification	01.07.01 *	Permanent Contract	3 months
Luke Bruce	Director of Policy and Communications	07.03.06	Permanent Contract	6 months
Patricia Le Rolland	Director of Quality	01.09.06	Permanent Contract	6 months

* Date applicable to contract with predecessor organisation.

Senior Managers' salaries

Name	Basic Salary (£) 2009/10	Non consolidated award for (£) 2009/10	Basic Salary (£) 2008/09	Non consolidated award (£) 2008/09	Real increase in pension at age 60 (£'000)
Paul Streets	62,493	0	132,155	6,608	0-2.5
Paula Harris	90,469	3,619	44,423	1,875	n/a
Lesley Hawksworth	86,063	3,443	79,431	4,250	0-2.5
Luke Bruce	86,063	3,443	78,278	4,250	0-2.5
Patricia Le Rolland	87,036	3,481	78,817	4,280	2.5-5.0

The non-consolidated payment was non-pensionable.

No amounts were payable to third parties for the services of any of the above senior managers. During the year no awards or compensation payments were made to senior staff. None of the senior managers received any of the following types of remuneration in 2009/10 or 2008/09: allowances; expenses allowance; benefits in kind; compensation for loss of office or termination of service.

Paul Streets resigned as Chief Executive on 31st August 2009 to take up a senior post in the Department of Health.

On the departure of Paul Streets, and in view of the remaining life of PMETB, the Board did not appoint a substantive replacement but instead contracted with MWTB Ltd to provide the services of an interim Chief Executive -Graham Smith - from 1st September 2009 with the targeted role of delivering the merger programme. MWTB Ltd was paid £146,060 under the contract, which continued until the date of the merger, 31 March 2010.

The following Senior Managers are members of the NHS Pension Scheme:

Name	Title	Value of accrued pension (£'000)	Related lump sum (£'000)	Real increase in related lump sum (£'000)	Cash equivalent Transfer Value as at 1 April 2009 (£'000)	Cash equivalent Transfer Value as at 31 March 2010 (£'000)	Real increase in the cash equivalent transfer value during the reporting year
Paul Streets	Chief Executive	10-15	35-40	15-20	135-137.5	255-260	80-85
Lesley Hawksworth	Director of Certification	0-5	12.5-15	2.5-5	75-77.5	105-110	20-25
Luke Bruce	Director of Policy and Communications	0-5	10-12.5	0-2.5	35-37.5	45-50	5- 10
Patricia Le Rolland	Director of Quality	35-40	110-120	10-15	737.5-740	860-865	70-75

Paula Harris did not join the NHS pension scheme.

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment paid by a pension scheme or arrangement to secure pension benefits in another scheme or arrangement when a member leaves the scheme and chooses to transfer the benefit accrued in the former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figure, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

There has been no compensation paid to former senior managers.

Board Members' Remuneration

Stuart Macpherson was the Chair of the Board and details of his remuneration as a Board Member are disclosed in the table below. Board Members' remuneration and the Chair's salary are not subject to superannuation. Board Members receive an annual remuneration of £9,000 (2008/09: £9,000).

No payments were made during the year to any Board members for loss of office.

Board members' remuneration during the year amounted to £350,620 (2008/09: £375,332), including social security costs and payments for additional responsibilities. Payments to individual members are disclosed in the following table:

	Year ended 31 March 2010 £	Year ended 31 March 2009 £
Dr Ikechuku Anya	9,000	9,000
Dr Chris Clough	9,000	9,000
Dr Nicola Cohen	9,000	3,986
Mr Ian Cumming (Deputy Chair)	9,000	9,000
Professor Neil Douglas	9,000	9,000
Professor Stephen Field ***	9,000	9,000
Mrs Susan Fox (Wales)	9,000	9,000
Mrs Frances Gawn (Northern Ireland)	9,000	9,000
Professor Janet Grant	9,000	9,000
Dr Patricia Hamilton	9,000	9,000
Professor David Haslam	9,000	9,000
Dr John Jenkins (Northern Ireland) ***	9,000	9,000
Dr Hasmukh Joshi	9,000	9,000
Dr Namita Kumar	9,000	9,000
Professor Stuart Macpherson (Scotland) (Chair) ***	80,750	5,014
Dr Johann Malawana	9,000	3,986
Dr Alastair McGowan	9,000	9,517
Dr Arun Midha	9,000	4,800
Professor David Neal	9,000	9,000
Dr Trevor Pickersgill (Wales) ***	9,000	9,000
Miss Jane Reynolds	9,000	9,000
Mrs Susanne Roff (Scotland)	9,000	9,000
Mr. Finlay Scott ***	9,000	9,000
Mr John Smith	9,000	9,000
Dr Anita Thomas ***	9,000	9,000

* Mr John Smith also acted as Chair of the Assessment Committee and received an additional £14,625 (2008/09: £4,875) for those services.

** £37,927 (2008/09 £9,275) was paid to Queens University, Belfast in respect of costs related to additional work carried out on behalf of Dr John Jenkins as Chair of the Training Committee.

*** Board fees so denoted were paid directly to their ultimate employer.

In addition, expenses amounting to £64,583 (2008/09: £116,732) were reimbursed to Board Members.

Certain of the disclosures in this remuneration report have been subject to audit. These include:-

- Salary and allowances, bonuses, expenses allowances, compensation for loss of office and non-cash benefits for each senior manager (this includes advisory and non-executive board members) who served during the year;
- Pensions for each senior manager who served during the year;
- Compensation payments to former senior managers; and
- Amounts payable to third parties for services of a senior manager.

Richard Douglas
Accounting Officer

23 September 2010

Statement of the Board's and the Accounting Officer's Responsibilities

Under the Cabinet Office's Guidance on Codes of Best Practice for Board Members of Public Bodies, the PMETB Board was responsible for ensuring propriety in its use of public funds and for the proper accounting of their use.

Under Section 13 of The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010 (The Order), the GMC is required to prepare a statement of accounts in respect of a period ending immediately before the appointed day of 1 April 2010 and may do anything else that appears to the General Council to be necessary or expedient in consequence of the abolition of the Board

The accounts are to be produced on an accruals basis and must give a true and fair view of the Board's state of affairs at the year end and of its net operating costs, recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the General Medical Council is required to:

- Observe the accounts direction issued by the Secretary of State, with the consent of the Treasury, including the relevant accounting and disclosure requirements;
- Apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- Prepare the statements on the going concern basis unless it is inappropriate to presume that the Board will continue in operation.

The Permanent Secretary of the Department of Health has assumed the role of PMETB's Accounting Officer. The responsibilities of the Accounting Officer, include responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the PMETB's assets.

Statement on Internal Control

The Accounting Officer of the Department of Health has been designated as Accounting Officer for the purposes of signing the Postgraduate Medical Education and Training Board (PMETB) Annual Report and Accounts for the year to 31 March 2010. The Chief Executive of PMETB, and on his departure the Interim Chief Executive of PMETB, were the Accounting Officers for PMETB during the year ended 31 March 2010.

Scope of responsibility

The PMETB Chief Executive as Accounting Officer supported by the PMETB Board had responsibility for maintaining a sound system of internal control that supported

the achievement of the Postgraduate Medical Education and Training Board (PMETB) policies, aims and objectives, whilst safeguarding the public funds and organisational assets for which the Accounting Officer was personally responsible, in accordance with the responsibilities assigned in Managing Public Money.

PMETB reported directly to the UK Parliament and worked closely with the Department of Health in delivering its statutory obligations as well as the key objectives of its Strategic and Operational Plans. This includes identifying and responding appropriately to both internal and external risks.

Accountability within PMETB was exercised through

- a governing board consisting of up to 29 members.

- a Senior Management Team of four Directors and the CEO as Accounting Officer.

- the Audit and Risk Sub-Committee of the Board who were charged with the responsibility of advising and monitoring the adequacy of risk management and who received reports on risk at all of their meetings.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives: it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of organisational policies, aims and objectives;
- Evaluate the likelihood of those risks being realised and the impact should they be realised; and
- Manage them efficiently, effectively and economically.

The system of internal control was in place in PMETB for the year ended 31 March 2010, and complied with Treasury guidance.

Capacity to handle risk

Responsibility for managing risk rested with the Chief Executive supported by the Directors. The Senior Management Team reviewed the risk register on a quarterly basis. Directors and Heads of Section were expected to understand and accept responsibility for the recognised risks associated within their areas of authority.

Responsibility for risk management policy and coordination lay with the Director of Finance and Resources to ensure that risk management was linked to corporate planning and performance monitoring.

The risk and control framework

PMETB's risk management policy sought to identify the risks facing the organisation and to treat them according to established guidelines. The risk appetite was low and managers made sound decisions on the risks that the organisation retained, those it sought to reduce through strategic or operational change, and those it transferred.

Progress reports to the Board included a reference to the risks attached to the

operational and strategic plans and the wider context for the work of the organisation. A Risk Register was created in 2006 and, from April 2007, the Risk Register clearly defined the risks associated with each of the Operational Plan priorities. Evaluation and control of risks was undertaken by defining the risk event and consequences and then assessing the controls. Since April 2007, the Board has received a report at each Board Meeting, showing the risks related to the Operational Plan, an assessment of their significance and how these risks are being managed.

The Audit and Risk Committee, a formally constituted sub-committee of the Board, provided independent assurance on all aspects of risk, governance and controls. They oversaw the risk management process and received regular updates on business and financial performance. This included the work of both the internal and external audit.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures were in place to ensure all employer obligations contained within the Scheme regulations were complied with. This included ensuring that deductions from salary, employer contributions and payments in to the Scheme were in accordance with Scheme rules, and that members Pension Scheme records were accurately updated in accordance with the timescales detailed in the regulations.

The Head of Internal Audit provided a “satisfactory” level of assurance on the overall adequacy and effectiveness of PMETB’s risk management, control and governance processes (i.e. the system of internal control) for 2009/10, on the basis of the work undertaken by South Coast Audit.

Following the issue of data security in the public sector, we reviewed our processes for the handling of personal information and our compliance with the Data Protection Act.

We worked to improve our information governance systems as a result of the analysis conducted as part of the Department of Health’s Information Governance Toolkit. An Information Risk policy was introduced The Director of Finance and Resources was appointed as PMETB’s Senior Information Risk Officer reporting to the Audit and Risk Committee and the Board accordingly.

Information Risk Incidents

There were two incidents connected with information:

1) In January 2010 a third party unconnected to the applicant was given information about the progress of the applicants’ application as well as information about the length of time taken by the applicant to submit relevant details.

2) In February 2010 personal data for one applicant was accidentally returned to another applicant. The information was safely returned by the applicant who had incorrectly received it and was then sent to the correct applicant. Both parties received apologies for the mistake.

Review of effectiveness

The Accounting Officer had responsibility for reviewing the effectiveness of the system of internal control. The review of the effectiveness of the system of internal

control in place during 2009/10 was informed by the work of the internal auditors and the Senior Management Team, who have responsibility for the development and maintenance of the internal control framework. .

The Accounting Officer was advised on the implications of the result of the review of the effectiveness of the system of internal control by the Board, and the Audit and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system was in place.

Risk management has been an ongoing process and continued to be integral to the strategic and operational planning and to the delivery of the targets agreed in our Funding Agreement with The Department of Health.

The review of the effectiveness was informed by the Head of Internal Audit opinion, by comments made by the external auditors in their management letter and other reports as well as by advice from the Audit and Risk Committee and the Board.

Internal and External Audit

PMETB had an internal audit service provided by South Coast Audit and external audit services provided by Baker Tilly UK Audit LLP and the National Audit Office (NAO). The Head of Internal Audit reported to the Audit and Risk Committee regularly to standards defined in the Government Internal Audit Standards. These reports included an independent audit opinion on the adequacy and effectiveness of PMETB's system of internal control and made recommendations for improvement.

The Head of Internal Audit provided a "Satisfactory" opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

I have obtained some assurance from the Interim Chief Executive of PMETB who was responsible for the activities relating to the period from September 2009 to March 2010. I will also take into account the annual report of PMETB's internal auditors and the reports of both Baker Tilly UK Audit LLP and the NAO and any other information that I become aware of in the period 1 April 2010 to the date of the signing of these accounts.

On 1 April 2010 the staff, duties, assets and liabilities of PMETB were transferred to the General Medical Council (GMC) or to the Department of Health (DH). The GMC commissioned an independent review of PMETB's systems to provide comfort that there were no major outstanding issues.

Richard Douglas
Accounting Officer

23 September 2010

Independent Auditor's Report to the Permanent Secretary to the Department of Health regarding the Annual Report and Accounts of the Postgraduate Medical Education and Training Board (PMETB) for the Year Ended 31 March 2010

We have audited the financial statements on pages 45 to 78. We have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Permanent Secretary to the Department of Health who, for the purposes of these financial statements, is acting as the Accounting Officer of PMETB in accordance with the requirements established by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010. Our audit work has been undertaken so that we might state to the Permanent Secretary to the Department of Health those matters we are required to state to him in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Permanent Secretary to the Department of Health for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Board of PMETB, the Chief Executive of PMETB, the General Medical Council (GMC), the Department of Health and the Auditor

The GMC are responsible for the preparation of the financial statements, the remuneration report, and other contents of the Annual Report in accordance with the above mentioned Order and as directed by the Secretary of State for the Department of Health with the consent of HM Treasury. The Board of PMETB and its Chief Executive have been responsible for ensuring the regularity of financial transactions during the year under review.

Our responsibility is to audit the financial statements and the part of the Remuneration Report to be audited in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view and are properly prepared in accordance with the Government Financial Reporting Manual issued by HM Treasury for the year ended 31 March 2010 which applies International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context; and the General and Specialist Medical Practice (Education, Training and Qualifications) Orders 2003 and 2010 and directions made thereunder; and whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and that those financial transactions conform to the authorities which govern them. We also report whether in our opinion the information given in the Management Commentary is consistent with the financial statements.

In addition, we report to you if in our opinion the Board has not kept proper accounting records, or if we have not received all the information and explanations we require for our audit.

We review whether the Statement on Internal Control (pages 36 to 39) reflects the PMETB's compliance with HM Treasury's guidance on the Statement on Internal Control. We report if it does not meet the requirements specified by HM Treasury of if

the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, whether the Statement on Internal Control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the PMETB's corporate governance procedures or its risk and control procedures.

We read other information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. This other information comprises only the Management Commentary, the unaudited part of the Remuneration Report, and the reports on pages 5 to 39 and 79 to 88. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

Basis of audit opinion

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures, and regularity of financial transactions, included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgements made by the Board, the Chief Executive and the General Medical Council in the preparation of the financial statements, and of whether the accounting policies are appropriate to the PMETB's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or other irregularity or error and that, in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In forming our opinion we have also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion
In our opinion:-

- the financial statements give a true and fair view of the state of affairs of PMETB as at 31 March 2010 and of the operating costs, income, grant in aid funding and cash flows for the period then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the Government Financial Reporting Manual issued by HM Treasury for the year ended 31 March 2010 which applies International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context; the General and Specialist Medical Practice (Education, Training and Qualifications) Orders 2003 and 2010; and directions made thereunder; and
- the information given in the Management Commentary is consistent with the financial statements.

Opinion on other matters prescribed by the General and Medical Specialist Practice (Education, Training and Qualifications) Orders 2003 and 2010:-

- In all material respects the expenditure and income have been applied to the purposes intended by Parliament and those financial transactions conform to the authorities which govern them.

BAKER TILLY UK AUDIT LLP
Registered Auditor and Chartered Accountants
The Clock house
140 London Road
Guildford
Surrey
GU1 1UW

24 September 2010

POSTGRADUATE MEDICAL EDUCATION AND TRAINING BOARD

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSES OF PARLIAMENT

I certify that I have audited the financial statements of the Postgraduate Medical Education and Training Board for the year ended 31 March 2010 under the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. These comprise the Operating Cost Statement, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Reserves and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of the Board's and the Accounting Officer's Responsibilities, the General Medical Council is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the Audit of the Financial Statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Postgraduate Medical Education and Training Board's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Postgraduate Medical Education and Training Board's circumstances; and the overall presentation of the financial statements.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on Regularity

In my opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of Postgraduate Medical Education and Training Board's affairs as at 31 March 2010 and of its net operating cost, changes in reserves and cash flows for the year then ended; and

- the financial statements have been properly prepared in accordance with the General and Specialist Medical Practice (Education, Training and

Qualifications) Order 2003 and Secretary of State directions issued thereunder.

Opinion on other matters

7. In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions issued under by General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003; and

- the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or

- the financial statements are not in agreement with the accounting records or returns; or

- I have not received all of the information and explanations I require for my audit; or

- the Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Amyas C E Morse

Comptroller and Auditor General

National Audit Office

157-197 Buckingham Palace Road

Victoria

London

SW1W 9SP

30 September 2010

PMETB Operating Cost Statement for the year ended 31 March 2010

	Note	Year ended 31 March 2010		Year ended 31 March 2009	
		£	£	£	£
Staff costs	4	2,970,585		3,310,261	
Board members' remuneration	3	350,620		375,332	
Other operating costs	6	3,545,129		3,332,732	
Depreciation and amortisation	9	595,508		241,384	
Notional cost of capital	8	41,148		59,176	
Gross operating cost			7,502,990		7,318,885
Operating income	7		5,249,330		5,172,827
Net operating cost before interest			2,253,660		2,146,058
Finance income			495		39,255
Net Operating Cost for the year			2,253,165		2,106,803

All operations are continuing. There were no material acquisitions in the year, and all assets were written down at the end of the year due to the merger with the General Medical Council.

The notes on pages 51 to 78 form part of these financial statements

PMETB Statement of Changes in Reserves

	General Reserve
	£
Balance as at 1 April 2008	2,009,161
Net operating costs for the year	(2,106,803)
Grant in aid funding	1,425,000
Notional cost of capital	59,176
Balance as at 31 March 2009	1,386,534

	General Reserve
	£
Balance as at 1 April 2009	1,386,534
Net operating costs for the year	(2,253,165)
Grant in aid funding	1,790,258
Notional cost of capital	41,148
Balance as at 31 March 2010	964,775

Reconciliation of reserves as at 31 March 2009 prepared under UK GAAP to reserves at 31 March 2009 under IFRS

	General reserve	Revaluation reserve	Total
Balance as previously published in financial statements prepared under UK GAAP	1,407,914	3,869	1,411,783
Accrual for holiday entitlement c/f as at 31 March 2009 under IAS 19	(38,402)		(38,402)
Reversal of indexation of property, plant and equipment under IAS 16	13,153		13,153
Transfer of revaluation reserve as indexation of assets no longer applied under IFRS	3,869	(3,869)	0
Total	1,386,534	0	1,386,534

Impact on the net operating cost

As previously stated in the 31 March 2009 financial statements prepared under UKGAAP	2,106,524
Additional staff costs for accrued holiday entitlement	38,402
Reversal of indexation as above	(13,153)
Change in notional cost of capital due to the above changes	(1,246)
Unrealised gains on fixed asset indexation formerly stated in the Statement of Recognised Gain and Losses	(23,724)
Net operating cost as stated under IFRS for the year ended 31 March 2009	2,106,803

The above changes have no impact on cash and cash equivalents

PMETB Statement of Financial Position as at 31 March 2010

	Note	31-Mar-10 £	31-Mar-09 £	31-Mar-08 £
Non-Current Assets				
Property, plant and equipment	9	0	458,668	633,337
Intangible assets	10	0	129,940	0
Total non-current assets		0	588,608	633,337
Current Assets				
Trade and other receivables	11	88,484	58,126	180,268
Cash and cash equivalents	12	1,982,584	1,985,157	2,890,172
		2,071,068	2,043,283	3,070,440
Total assets		2,071,068	2,631,891	3,703,777
Current liabilities				
Trade and other payables	13	1,106,293	1,125,357	1,694,616
Provisions	14	0	120,000	0
Total liabilities		1,106,293	1,245,357	1,694,616
Net Assets		964,775	1,386,534	2,009,161
Reserves				
General Reserve		964,775	1,386,534	2,009,161
		964,775	1,386,534	2,009,161

Signed on behalf of the Postgraduate Medical Education and Training Board

Richard Douglas
Accounting Officer

23 September 2010

PMETB Statement of Cash Flow for the year ended 31 March 2010

	Year ended 31 March 2010	Year ended 31 March 2009
	£	£
Net operating cost	(2,253,165)	(2,106,803)
Notional cost of capital	41,148	59,176
Finance income	(495)	(39,255)
Depreciation	595,508	241,384
(Increase)/decrease in trade and other receivables	(30,358)	122,142
(Decrease) in trade and other payables	(19,064)	(569,259)
Increase/(decrease) in provisions	(120,000)	120,000
Net cash outflow from operating activities	(1,786,426)	(2,172,615)
Cash flows from investing activities		
Interest received	495	39,255
(Payments) for property, plant and equipment	(6,900)	(41,582)
(Payments) for intangible assets		(155,073)
Net cash (outflow) from investing activities	(6,405)	(157,400)
Net cash (outflow) before financing	(1,792,831)	(2,330,015)

Cash flows from financing activities		
Grant in aid funding received from the DH	1,790,258	1,425,000
Net (decrease) in cash and cash equivalents	(2,573)	(905,015)
Cash and cash equivalents at the beginning of the financial year	1,985,157	2,890,172
Cash and cash equivalents at the end of the financial year	1,982,584	1,985,157

PMETB Notes to the Accounts

Note 1: Accounting Policies

a Basis of preparation

These financial statements have been prepared in accordance with The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010; the Accounts Direction given by the Secretary of State with the consent of HM Treasury; and with the 2009/10 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in that FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. The date of transition to IFRS was 1 April 2008. Where this FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of PMETB for the purpose of giving a true and fair view has been selected. The particular accounting policies adopted by the Board are described below. They have been applied consistently in dealing with items considered material in relation to these financial statements.

The preparation of the financial statements in conformity with this FReM requires the use of certain critical accounting estimates. It also requires management to exercise judgement in the process of applying the Board's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements are described in note c below. Although these estimates are based on management's best knowledge of the amount, event or actions, actual results ultimately may differ from those estimates.

b Accounting convention

The financial statements have been prepared under the historical cost convention as modified for the valuation of certain assets and liabilities at fair value. These financial statements have been prepared on the basis that PMETB is a going concern as although the Board merged with the General Medical Council (GMC) on 1 April 2010, its statutory duties will continue to be fulfilled after this date by the GMC. The assets of the Board have been transferred to the GMC, where the GMC can use them to perform PMETB's former functions.

c Critical judgements in applying accounting policies and key sources of estimation uncertainty.

Estimates and judgements are continually evaluated and based on historical experience as adjusted for current market conditions and other factors.

The Board makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the actual related results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below.

Provisions
The Board's estimate of the value of the provision regarding dilapidation of the Board's current office premises is based on evidence provided following a professional review of the premises and discussion with the landlord.

Intangible assets – Computer software
The Board incurred costs developing software for an on-line certification system. Judgements were made regarding valuation and the asset's useful life. The asset has been recognised at cost incurred since the asset met appropriate recognition criteria.

Intangible assets – Assets in the course of construction
Capital software projects which are incomplete at the balance sheet date are included in this category. Judgement is exercised above. Once the projects are brought into use they are transferred to computer software costs.

Income recognition
Where applications for registration span more than one accounting period judgement is made to determine the appropriate proportion of value delivered and the extent to which fees are recoverable.

d Accounting standards and interpretations not yet adopted

In the preparation of the these financial statements the Board have adopted in full the HM Treasury Financial Reporting Manual 2009-10 as applicable under International Financial Reporting Standards (iFReM). IFRS standards that are issued but not yet applicable to this accounting period are as follows:

- IFRS 9 Financial instruments
- IFRIC 17 Distributions of non-cash assets to owners
- IFRIC 18 Transfers of assets to customers
- IFRIC 19 Extinguishing financial liabilities with equity instruments

The Board consider that these will not be material to future financial statements.

e Grant in Aid funding
The Board receives Grant in Aid income from the Department of Health, which is treated as financing of the Board's activities and credited to the General Fund Reserve. It is recognised when received.

f Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

In accordance with IAS 19, the cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period. The impact of the adoption of this accounting standard is explained in the notes to the accounts.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Board commits itself to the retirement, regardless of the method of payment.

A full actuarial valuation of the NHS Pension Scheme was carried out as at 31 March 2004 and published in December 2007. Details of this valuation and the benefits provided by the scheme are provided in the Government Actuary's Department report available on the NHS Business Services Authority website www.nhsbsa.nhs.uk. This valuation sets out the deficit of the scheme which at 31 March 2004 amounted to £3.3 billion

Under the NHS Pension Scheme Regulation (SI 1995 No. 300), the Board is required to pay an employer's contribution, currently 14% of pensionable pay, as specified by the Secretary of State. These contributions are charged to the operating cost statement as and when they become due. The Government Actuary reviews the employer contributions every four years following a full scheme valuation and sets contribution rates to reflect past experience and benefits when they are accrued, not when costs are actually incurred.

Employees pay 6% of pensionable pay. Employer and employee contributions are used to defray the cost of providing the scheme benefits. These are guaranteed by the Exchequer, with the liability falling to the Secretary of State, not to the Board. Index linking costs under the Pensions (Increase) Act 1971 are met directly by the Exchequer.

g Notional charges

In accordance with the 2010 Financial Reporting Manual published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the operating cost statement. The cost of capital charge is calculated at 3.5% (2008/09: 3.5%), applied to the mean value of capital employed during the year, excluding non-interest bearing cash balances held with the Office of the Paymaster General. The charge is offset by a corresponding credit to the General Reserve. The charge is not actually paid.

h Value added tax

PMETB, as an eligible body, is exempt from VAT. Output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets.

i Income recognition

Operating income comprises fees for applicants to gain eligibility for entry on the registers of specialists or general practitioners, or as medics who have completed training. Fees for appeals and the review process are also included.

This certification is made under Articles 10-14, 20 and 50 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003.

Operating income is recognised initially on receipt of the fee and completion of initial checks. However, the complexity of individual applications and hence the time to process them can vary considerably. Where applications span more than one accounting period the amount of income recognised in the accounting period is calculated to reflect, on average, the work performed to the end of the accounting period. The methodology for this is that the amount deferred, at the year end, is the element of the fee refundable to the applicant given the progress already made on their case. In addition, sufficient income is deferred in order to meet fees payable to Royal Colleges in respect of relevant applications.

The Order provides that PMETB set fees at levels to cover direct costs and a proportion of overheads as are reasonably attributable to the performance of this function without a profit element.

j Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

k Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the Board;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £1,000; or

● Collectively, a number of items have a cost of at least £1,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Valuation

All properties, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Until 31 March 2008, leasehold improvements, information technology and furniture and fittings were been carried at replacement cost, as assessed by indexation and depreciation of historic cost. The indexation movements were reflected in a revaluation reserve. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over the assets remaining useful lives. New additions will be recognised as stated above. Where assets have a short useful life they will be carried at depreciated historic cost where is this not materially different from fair value. As can be seen in the Statement of Changes in Reserves the indexation adjustments from previous accounting periods have been reversed.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

I Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the PMETB's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Board; where the cost of the asset can be measured reliably, and where the cost is at least £1,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
● the technical feasibility of completing the intangible asset so that it will be available for use
● the intention to complete the intangible asset and use it

● the ability to sell or use the intangible asset

● how the intangible asset will generate probable future economic benefits or service potential

● the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it

● the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is

recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

m Depreciation, amortisation and impairments

Depreciation and amortisation are charged to write off the costs or valuation of refurbishment costs, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. A straight-line basis is used to reflect this. The estimated useful life of an asset is the period over which PMETB expects to obtain economic benefits or service potential from the asset. This is specific to PMETB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

The useful lives of tangible non-current assets have been estimated as follows:

Leasehold improvements	5 years
Furniture and fittings and Computer equipment	Between 3 – 10 years

Depreciation is charged from the month following that in which the asset is acquired. Intangible assets are to be written down to £nil where they have no long term use with the organisation after the merger with GMC.
At each reporting period end, PMETB checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

n Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

PMETB as lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term

o Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of PMETB's cash management.

p Provisions

Provisions are recognised when PMETB has a present legal or constructive obligation as a result of a past event, it is probable that PMETB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

q Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of PMETB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of PMETB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

r Financial assets

Financial assets are recognised when PMETB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services

have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value and classified at the time of initial recognition.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Board assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

s Financial liabilities
Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

t Losses and Special Payments

Losses and special payments are items that the Department of Health or Parliament would not have contemplated when they agreed funds or passed legislation respectively. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments.

They are charged to the relevant functional headings in expenditure on an accruals basis.

2 Reconciliation of Net Operating Cost to Financing Received from the UK Government

		Year ended 31 March 2010	Year ended 31 March 2009
		£	£
Net Operating Cost for the period		(2,253,165)	(2,106,803)
Financing received from the Department of Health		1,790,258	1,425,000
Overspend against Financing received from the Department of Health		(462,907)	(681,803)

3 Board members' remuneration

			Year ended 31 March 2010		Year ended 31 March 2009
			£		£
Payments to Chair			80,750		65,000
Payments in respect of additional responsibilities of Chairs of Statutory Committees			52,552		83,292
Fees			200,250		212,018
Social security costs			17,068		15,022
			350,620		375,332

4 Staff costs

	Year ended 31 March 2010	Year ended 31 March 2009
	£	£
Salaries	2,132,126	2,204,767
Social security costs	187,477	192,589
Superannuation costs	238,511	239,741
Agency/Temporary costs	412,471	673,164
	2,970,585	3,310,261

5 Average number of staff

	Year ended 31 March 2010	Year ended 31 March 2009

The average number of full time equivalent staff was as follows:

Administration	14	19
Appeals	2	2
Certification	23	27
Policy and Communications	13	15
Quality	17	16
Total	69	79
Permanent	55	58
Temporary	14	21
Total	69	79

6 Other Operating Costs

			Year ended 31 March 2010		Year ended 31 March 2009
			£		£
Professional fees			364,814		501,896
Rent and office accommodation			313,357	*	301,828
Provision for dilapidations			(100,000)		120,000
Training and recruitment			119,094		182,325
ICT costs, computer consumables and website costs			267,660		288,703
Printing and stationery			416,022	**	423,445
Board members' expenses			257,753	***	116,732
Room Hire			97,825		93,114
External audit fee			68,204		30,503
Fees to external auditor for other services			4,888		8,500
Support to Royal Colleges			425,442		652,715
Quality Assurance			410,883		221,846
Appeals costs			72,100		90,727
Merger costs			284,334		28,896
Other costs			542,753	****	271,502
Total other operating costs			3,545,129		3,332,732

* Rent and office accommodation includes £192,852 (08/09 £168,000) in respect of operating leases for land and buildings.

** Printing and stationery includes £17,946 (08/09 £16,810) in respect of operating leases for plant and equipment.

*** Board members' expenses include a provision of £155,000 for the tax liability on Board members' travel and subsistence.

**** Other Costs includes £165,000 in respect of run off insurance to cover the decisions of Board members and Partners; £81,302 in respect of a potential liability for PAYE and NIC regarding the employment status of the former Chief Executive; and a £25,000 provision for the potential cost of an ongoing employment dispute.

7 Fee Income

	Year ended 31 March 2010	Year ended 31 March 2009
	£	£
CCT	4,227,215	3,996,324
CESR & CEGPR	903,699	1,011,800
Appeals, reviews, other	118,416	164,703
	5,249,330	5,172,827

PMETB considers that it has only 1 reportable business segment as no discrete financial information is available for the costs related to the issuing of different certificates

8 Notional Cost of Capital

The Financial Reporting Manual published by HM Treasury, requires that a notional charge for the cost of capital employed during the year is included in the Operating Cost Statement along with an equivalent notional income to finance the charge. The cost of capital charge of 3.5 per cent is applied to the mean value of capital employed during the year, excluding non-interest bearing cash balances held with the Office of the Paymaster General.

	Year ended 31 March 2010	Year ended 31 March 2009
	£	£
Capital employed at 1 April 2009	1,386,534	2,009,161
Capital employed as at 31 March	964,775	1,386,534
Mean capital employed	1,175,655	1,697,848
Notional charge @ 3.5%	41,148	59,176

9 Property, Plant and Equipment

Property, plant and equipment	Leasehold Improvements	Information technology	Furniture & fittings	Total
	£	£	£	£
Cost/Valuation				
At 1 April 2008	574,579	563,074	161,445	1,299,098
Additions	0	41,582	0	41,582
Disposals	0	(31,759)	0	(31,759)
At 31 March 2009	574,579	572,897	161,445	1,308,921
Depreciation				
At 1 April 2008	268,179	324,418	73,164	665,761
Disposals	0	(31,759)	0	(31,759)
Charged during the year	117,440	64,342	34,469	216,251
At 31 March 2009	385,619	357,001	107,633	850,253
Net Book Value				
At 31 March 2009	188,960	215,896	53,812	458,668

Property, plant and equipment	Leasehold Improvements	Information technology	Furniture & fittings	Total
	£	£	£	£
Cost				
At 1 April 2009	574,579	572,897	161,445	1,308,921
Additions	0	6,900	0	6,900
Impairments	(71,816)	(161,651)	(21,709)	(255,176)
At 31 March 2010	502,763	418,146	139,736	1,060,645
Depreciation				
At 1 April 2009	385,619	357,001	107,633	850,253
Charged during the year	117,144	61,145	32,103	210,392
At 31 March 2010	502,763	418,146	139,736	1,060,645
Net Book Value				
At 31 March 2010	0	0	0	0

Depreciation as shown in the Operating Cost Statement for the year ended 31 March 2010 includes depreciation of property, plant and equipment of £210,392 and impairment of property, plant and equipment of £255,176, along with an impairment and charge for depreciation on intangible assets of £93,160 and £36,780 respectively (see note 10).

Property, plant and equipment was depreciated in accordance with the stated accounting policy. After this the Board carried out an impairment review to ensure that the carrying value of assets did not exceed the long term value in use of those assets to the GMC following the merger.

10 Intangible Non-current Assets

Intangible Assets	Assets under construction	Software costs	Total
	£	£	£
Cost			
At 1 April 2008	0	0	0
Additions	115,646	39,427	155,073
At 31 March 2009	115,646	39,427	155,073
Amortisation			
At 1 April 2008	0	0	0
Charged during the year	22,486	2,647	25,133
At 31 March 2009	22,486	2,647	25,133
Net Book Value			
At 31 March 2009	93,160	36,780	129,940

Intangible Assets	Assets under construction	Software costs	Total
	£	£	£
Cost			
At 1 April 2009	115,646	39,427	155,073
Impairments	(93,160)	0	(93,160)
At 31 March 2010	22,486	39,427	61,913
Amortisation			
At 1 April 2009	22,486	2,647	25,133
Charged during the year	0	36,780	36,780
At 31 March 2010	22,486	39,427	61,913
Net Book Value			
At 31 March 2010	0	0	0
At 31 March 2009	93,160	36,780	129,940

All assets are owned
There are no non-current assets held for sale
Assets under construction comprised the development of the Quality Framework System (QFIT). During the year the underlying software was found to be inadequate and the project was abandoned. After review the Board decided that the asset's carrying value was £nil. This abortive expenditure is detailed in note 15.
Software costs comprised the software for the Certification Online system. The brought forward carrying value was fully amortised in accordance with the stated accounting policy.

11 Trade and other receivables – current

	Current	31-Mar-10	31-Mar-09	01-Apr-08
		£	£	£
Prepayments		88,484	58,126	180,268
		88,484	58,126	180,268

There were no non-current trade or other receivables at the balance sheet date.

12 Cash at Bank and in Hand

	31-Mar-10	31-Mar-09	01-Apr-08
	£	£	£
At 1 April 2009	1,985,157	2,890,172	3,142,586
Net movement in the year	(2,573)	(905,015)	(252,414)
At 31 March 2010	1,982,584	1,985,157	2,890,172

13 Trade and other payables

	31-Mar-10	31-Mar-09	01-Apr-08
	£	£	£
Trade payables and accruals - revenue	570,881	306,889	725,287
Trade payables and accruals -capital	0	14,231	0
Deferred income	481,033	719,295	852,783
Other payables	54,379	84,942	116,546
	1,106,293	1,125,357	1,694,616

There were no non-current trade or other payables as at 31 March 2010 (2009: £nil)

14 Provisions

	31 March 2010	31 March 2009
	£	£
Brought forward at 1 April 2009	120,000	0
Charge in the year for provision for dilapidations	0	120,000
Release of provision	(120,000)	0
As at 31 March 2010	0	120,000

The provision represents the estimated cost of dilapidations relating to office accommodation occupied by PMETB at Hercules House.

15 Abortive expenditure on systems development

In 2008, PMETB contracted with a firm to provide consultancy services for some Open Source software which it had purchased. The programme was successfully implemented but then subsequently developed some problems in late January 2009 which caused it to crash and to lose information. PMETB reluctantly had to decide in February 2009 that it would have to suspend use of the software until the glitches could be resolved. The costs of this system were capitalised as assets in the course of construction and are shown in note 10.

PMETB worked with the supplier and consultancy firm for a number of months but in September 2009 after no solution was found for the problems it was decided to abandon the software and to write off the expenditure as a fruitless payment. This amounted to £93,160

16 First-time adoption of IFRS

Main changes brought about by the adoption of IFRA are:

Holiday Pay

An accrual has been included for holiday pay.

Fair value of property, plant and equipment

Following the transition to IFRS, fixtures, fittings and equipment are carried at depreciated historic cost as this is considered to be a good approximation to fair value given the nature of the assets. Indexation used to revalue these assets to replacement cost under UK GAAP has therefore been reversed.

Statement of financial position reconciliation as at 31 March 2008

	UK GAAP accounts in IFRS format	Adjustment under transition	Under IFRS
	£	£	£
Non-current assets			
Property, plant and equipment	632,307	1,030	633,337
Current assets	3,070,440	0	3,070,440
Current liabilities			
Trade and other payables	(1,661,832)	(32,783)	(1,694,616)
Net assets	2,040,915	(31,753)	2,009,161
Reserves - General	2,028,854	(19,692)	2,009,161
- Revaluation	12,061	(12,061)	0
Total	2,040,915	(31,753)	2,009,161

Adjustments:

£1,030 relates to the reversal of indexation.

£32,783 relates to holiday entitlement accrued by 31 March 2008

Statement of financial position reconciliation as at 31 March 2009

	UK GAAP accounts in IFRS format	Adjustment under transition	Under IFRS
	£	£	£
Non-current assets			
Property, plant and equipment	445,511	13,157	458,668
Intangible assets	129,940		129,940
Current assets	2,043,283		2,043,283
Current liabilities			
Trade and other payables	(1,086,951)	(38,406)	(1,125,357)
Provisions	(120,000)		(120,000)
Net assets	1,411,783	(25,249)	1,386,534
Reserves	1,411,783	(25,249)	1,386,534

Adjustments:-

£13,157 comprises reversal of the indexation as at 31 March 2008 (£1,030 see above), and further adjustment for indexation in 2009 of £12,127.

£38,406 accrual for staff benefit entitlement accrued in respect for holiday pay.

Operating cost statement reconciliation for the year to 31 March 2009

	UK GAAP accounts in IFRS format	Adjustments under IFRS transition	Under IFRS
	£	£	£
Staff costs	3,304,641	5,620	3,310,261
Board Members' remuneration	375,332		375,332
Other operating costs	3,332,731	1	3,332,732
Depreciation	245,480	(4,096)	241,384
Notional cost of capital	60,422	(1,246)	59,176
Gross operating cost	7,318,606	279	7,318,885
Operating income	5,172,827		5,172,827
Finance income	39,255		39,255
Net operating cost for the year	2,106,524	279	2,106,803

Adjustments:-

£5,620 increase in accrual for holiday pay (2009: £38,406 and 2008: £32,783) less £3 sundry expenses.

£4,096 reversal of indexation and consequent adjustment to depreciation

£1,246 adjustment to notional cost of capital as a result of the above changes

Statement of cash flow reconciliation for the year ended 31 March 2009

	UK GAAP accounts in IFRS format	Adjustment	Under IFRS
Cash flow from operating activities	£	£	£
Net operating cost for the year	(2,106,524)	(279)	(2,106,803)
Adjust for:-			
Cost of capital	60,422	(1,246)	59,176
Depreciation	245,480	(4,096)	241,384
Loss on disposal of fixed assets			
Interest received	(39,255)		(39,255)
Movement in receivables	122,142		122,142
Movement in provision	120,000		120,000
Movement in payables	(574,880)	5,621	(569,259)
Net cash outflow from operating activities	(2,172,615)		(2,172,615)
Cash flows from investing activities			
Interest received	39,255		39,255
Acquisition of PPE	(196,655)		(196,655)
Proceeds from PPE sales	-		-
Cash outflows from investing activities	(157,400)		(157,400)
Net cash outflow before financing	(2,330,015)		(2,330,015)
Cash flow from financing			
Grant in aid funding	1,425,000		1,425,000
Net decrease in cash	(905,015)		(905,015)
Cash b/f	2,890,172		2,890,172
Cash c/f	1,985,157		1,985,157

Adjustments:-

£279 is the net effect of adjustments as set out in the operating cost statement for the year ended 31 March 2009 reconciliation above.

£5,620 is the increase in the accrual for holiday pay

£4,096 is the reversal of indexation of non-current assets

£1,246 is the adjustment to the notional cost of capital due to the above

17 Contingent Liabilities

PMETB has terminated a contract with a supplier GOSS following that supplier's failure to deliver a computer system in accordance with their contractual obligations. PMETB made payments to the contractor in respect of two of the four phases of the contract (in respect of which it is considering its position to reclaim such sums) and does not consider that it has any liability in respect of the balance of the contract price which amounted to £164,729. Since June 2008 there has been no further discussion with GOSS on this matter. The matter remains unresolved.

18 Capital Commitments

The Board had no commitment for capital expenditure at the balance sheet date.

19 Related Party Transactions

The Board is a Non-Departmental Public Body sponsored by the Department of Health. The Department of Health is regarded as a related party. During the period to 31 March 2010 the Department of Health made payments totalling £1,790,258 in respect of funding for PMETB for the year 2009/10.

PMETB has contracts with a number of Medical Royal Colleges and Faculties specifying how they would assist PMETB with various aspects of its activities. Payments made in 2009/10 in respect of this assistance are disclosed below where relevant. The following Board Members were post holders of Royal Colleges and Faculties during 2009/10:

Dr Patricia Hamilton	President of the Royal College of Paediatrics and Child Health who were paid £24,425 in 2009/10
Professor Stephen Field	Chairman of the Royal College of General Practitioners
Professor David Haslam	President of the Royal College of General Practitioners who were paid £40,675 in 2009/10
Dr Hasmukh Joshi	Council Member and Vice Chairman of the Royal College of General Practitioners
Professor David Neal	Council Member of the Royal College of Surgeons of England who were paid £100,800 in 2009/10.
Professor Sir Neil Douglas	President of the Royal College of Physicians of Edinburgh

The Board maintained a register of interests for the Chair and Board Members, which was updated periodically by the Board Secretary to reflect any change in Board Members' interests. During the year ended 31 March 2010 no Board Member undertook any transaction with the Board in a personal capacity.

20 Losses and special payments

There were no material losses or special payments made during the financial year.

The abortive payment on software development of £115,646 is summarised in note 15.

21 Events after the Reporting Period

Following legislation passed in 2010, PMETB merged with the General Medical Council (GMC) on 31 March 2010. In view of the merger the Board reviewed the carrying value of non-current assets so that the carrying value reflected the value in use to the GMC. As a result of this non-current assets were impaired by £255,176 and have a book value of £nil at 31 March 2010.
The Board also provided run off insurance to indemnify the Board members and partners for the next six years. This cost £165,000 and the expense is included in Other Operating Costs (note 6).

These accounts were approved and authorised for issue on 23 September 2010.

22 Financial Instruments

The Postgraduate Medical Education and Training Board has no borrowings. To the extent that costs are not covered by operating income the Board is dependent upon departmental funding as agreed in advance each year. To date funding received in excess of need has resulted in a general reserve of £964,775. Given the low level payables and the fact that the Board is not significantly exposed to liabilities due to any one supplier, the Board does not consider liquidity or market risk to be significant for PMETB. The remaining cash balance, after reimbursing the GMC for discharge of remaining PMETB liabilities is to be paid back to the Department of Health.

The Board has no trade receivables and has £1,982,584 in current and deposit accounts with UK bankers and reviews the risk to these deposits regularly. As the PMETB is not dependent upon investment income received, in the current economic environment, the Board considers that there are no significant market or liquidity risks related to its financial assets. All material financial instruments are denominated in sterling, and so the Board is not exposed to currency risk.
Further information on financial risks is given in note 25.

23 Operating lease commitments – minimum lease payments

Total non-cancellable operating lease rentals are payable as follows:

	31 March 2010	31 March 2009
	£	£
Land and Buildings:		
Less than 1 year	88,484	
1 to 2 years	-	176,500
Plant and Equipment:		
Less than 1 year	8,500	8,500

PMETB leases office premises and various items of office equipment under non cancellable operating leases. These leases have various terms and renewal rights. Operating lease payments recognised as an expense are shown in note 6 to these financial statements.

None of these leases includes contingent rentals

24 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at ww.pensions.nhsbsa.nhs.uk. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

25 Risks

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationship that the PMETB has with its sponsoring department, the Department of Health, PMETB is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. PMETB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing PMETB in undertaking its activities.

PMETB's treasury management operations are carried out by the finance department, within parameters defined formally within the PMETB's standing financial instructions and policies agreed by the board of PMETB. PMETB treasury activity is subject to review by PMETB's internal auditors.

Currency risk
PMETB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. PMETB has no overseas operations. PMETB therefore has low exposure to currency rate fluctuations.

Interest rate risk
PMETB is exposed to interest rate risk as it earns interest on cash balances linked to base rate interest.
PMETB has no borrowings. It is assisted financially by grant in aid funding from the Department of Health in accordance with agreed business plans. The Board therefore consider that PMETB has low exposure to interest rate fluctuations. No sensitivity analyses have been presented on the basis that modest changes in interest rate (deemed to be 0.5% increase or decrease) do not have a material impact on PMETB.

Credit risk

Because the majority of PMETB's income comes from cash sales, PMETB has low exposure to credit risk. PMETB has no borrowings.

Liquidity risk

PMETB closely monitored it's bank balances in comparison to it's outstanding commitments on a regular basis to ensure it had funds to meet obligations as they fell due.

PMETB is financed by the certification application fees, other related fees and grant in aid funding from the Department of Health. PMETB works to an annually agreed business plan and is in constant dialogue with its sponsoring department. In this way unexpected changes in circumstances can quickly be addressed. Statute requires PMETB to set its fees at a level without incorporation of a profit element and in view of this the Department in expected to continue to provide funding whilst PMETB remains an NDPB. PMETB is not, therefore, exposed to significant liquidity risks.

Contact details

PMETB merged with the General Medical Council on 1 April 2010. Enquiries relating to this report should be directed to the GMC.

LONDON
Regent's Place. 350 Euston Road, London

MANCHESTER
3 Hardman Street, Manchester, M3 3AW

SCOTLAND
5th Floor, The Tun 4 Jackson's Entry, Holyrood Road, Edinburgh EH8 8PJ

WALES
Regus House, Falcon Drive, Cardiff Bay, CF10 4RU

NORTHERN IRELAND
9th Floor, Bedford House, 16 -22 Bedford Steet, Belfast, BT2 7FD

Doctors, employers and members of the public can contact the GMC by calling the Contact Centre

- Inside the UK: 0161 923 6602
- Outside the UK: +44 161 923 6602

by using our Online webform (opens in a new window).
by email: gmc@gmc-uk.org (opens in a new window).

An archive of PMETB information can be found in
the GMC's web site: http://www.gmc-uk.org/about/PMETB_archive.asp

The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Annex 1: Equality and Diversity Report

This is an analysis of data for reporting year 2009/2010. Please note that the data set covers the period between April 2009 and mid February 2010.

List of Tables

Respondents by Ethnic Origin

by Ethnic Origin	CCT GP	CCT Spec	CESR Article 14	CEGPR Article 11	CESR Article 14	CEGPR Article 11
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
Declined to answer (Blank)	14	23	8	0	2	0
African	18	25	5	1	2	0
Any other background	7	31	6	1	0	0
Asian Other	20	31	8	2	1	0
Bangladeshi	4	6	0	0	0	0
Black Other	0	1	0	0	0	0
British English	145	322	17	16	1	0
British Other	20	33	1	0	1	0
British Scottish	26	63	0	6	0	0
British Welsh	18	20	2	0	0	0
Caribbean	0	4	0	0	1	0
Chinese	6	33	2	0	0	0
Indian	95	242	30	7	12	0
Irish	10	25	0	3	0	0
Mixed Other	1	7	4	1	0	0
Pakistani	26	22	15	3	5	0
White and Asian	4	9	2	0	2	0
White and Black African	1	4	2	0	1	0
White and Black Caribbean	0	0	0	0	0	0
White Other	20	52	13	5	8	2
Total	435	953	115	45	36	2
Total Decisions Issued	1850	2931	138	269	23	248
Response Rate	24%	33%	83%	17%	157%	1%

Respondents by Gender

by Gender	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
Female	216	367	30	29	1	7
Male	218	584	15	86	1	29
Blank	1	2	0	0	0	0
Total	**435**	**953**	**45**	**115**	**2**	**36**
Total Decisions Issued	1850	2931	138	269	23	248
Response Rate	24%	33%	33%	43%	9%	15%

Respondents by Disability

by Disability	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
Without Disability	429	945	45	111	2	36
With Disability	3	5	0	4	0	0
Declined to Answer	0	0	0	0	0	0
Total	**432**	**950**	**45**	**115**	**2**	**36**
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	23%	32%	33%	43%	9%	15%

Respondents by Religion

by Religion	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
Buddhist	7	22	1	5	0	0
C of E	29	102	5	4	0	1
Catholic	33	77	3	6	0	1
Christian	120	215	13	21	1	3
Hindu	73	170	6	22	0	9
Jewish	6	15	0	2	0	1
Muslim	53	87	4	37	0	14
No Faith	90	199	10	13	1	2
Other	11	18	2	3	0	3
Sikh	5	9	1	0	0	0
Blank	8	39	0	2	0	2
Total	**435**	**953**	**45**	**115**	**2**	**36**
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	24%	33%	33%	43%	9%	15%

Respondents by Family Circumstances

by Family Circumstance	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
Civil Partner	6	25	2	3	1	1
Married	311	721	33	98	1	33
Single	112	181	10	13	0	2
Blank	6	26	0	1	0	0
Total	**435**	**953**	**45**	**115**	**2**	**36**
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	24%	33%	33%	43%	9%	15%

Respondents by Sexual Orientation

by Sexual Orientation	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
Bisexual	1	0	0	0	0	0
Gay	5	19	2	1	1	0
heterosexual	405	855	41	102	1	34
Lesbian	1	5	0	0	0	0
Other	0	5	0	0	0	0
Prefer not to answer	17	45	1	11	0	2
Blank	6	24	1	1	0	0
Total	**435**	**953**	**45**	**115**	**2**	**36**
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	24%	33%	33%	43%	9%	15%

Respondents by Dependants

by Dependents	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
No	232	314	20	26	1	8
Yes	195	616	25	84	1	29
Blank	8	23	0	5	0	0
Total	**435**	**953**	**45**	**115**	**2**	**37**
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	24%	33%	33%	43%	9%	15%

Respondents by Family Circumstance

by Family Circumstance	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
Civil Partner	6	25	2	3	1	1
Married	311	721	33	98	1	33
Single	112	181	10	13	0	2
Blank	6	26	0	1	0	0
Total	**435**	**953**	**45**	**115**	**2**	**36**
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	24%	33%	33%	43%	9%	15%

Respondents by Country of Primary Medical Qualification

Respondents by Country of PMQ	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
United Kingdom	273	571	2	2	0	0
Overseas	162	382	43	113	2	36
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	9%	13%	31%	42%	9%	15%

Respondents by Country where Completed the majority of Postgraduate Medical Training

Respondents by Country of PG Training	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
country	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
United Kingdom	410	905	32	66		14
Overseas	25	48	13	49	2	22
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	1%	2%	9%	18%	9%	9%

Respondents by Country of Postgraduate Medical Qualification

Respondents by Country of PG qualification	CCT GP	CCT Spec	CEGPR Article 11	CESR Article 14	CEGPR Article 11	CESR Article 14
	Awarded	Awarded	Awarded	Awarded	Rejected	Rejected
United Kingdom	413	892	35	74		14
Overseas	22	62	10	41	2	23
Total Decisions Issued	1,850	2,931	138	269	23	248
Response Rate	1%	2%	7%	15%	9%	9%

Annex 2: Board Members 2009-2010

Postgraduate Medical Education and Training Board Members	
Professor Stuart G Macpherson	Chairman
Dr Ike Anya	Medical member
Dr Chris Clough	Medical member
Mr Ian Cumming	Lay member
Dr Nicki Cohen	Medical member
Professor Sir Neil Douglas	Medical member
Professor Stephen Field	Medical member
Mrs Susan Fox	Lay member
Mrs Frances Gawn	Lay member
Professor Janet Grant	Lay member
Dr Patricia Hamilton	Medical member
Professor David Haslam	Medical member
Dr Johann Malawana	Medical member
Dr John Jenkins	Medical member
Dr Hasmukh Joshi	Medical member
Dr Namita Kumar	Medical member
Professor Alastair McGowan	Medical member
Dr Arun Midha	Lay member
Professor David Neal	Medical member
Dr Trevor Pickersgill	Medical member
Miss Jane Reynolds	Lay member
Mrs Susanne Roff	Lay member
Mr Finlay Scott	Lay member
Mr John Smith	Medical member
Dr Anita Thomas	Medical member

Annex 3: Glossary of Terms

Terms, acronyms and abbreviations used within this document.

Article 11: another term for a CEGPR (see below).

Article 14: another term for a CESR (see below).

CCT: Certificate of Completion of Training **–** The award of a CCT confirms that a doctor has satisfactorily completed a PMETB approved training programme.

CEGPR: Certificate confirming Eligibility for GP Registration – The award of a CEGPR signifies that a doctor has successfully demonstrated that their training, qualifications and experience are deemed equivalent to the award of a GPCCT.

CESR: Certificate confirming Eligibility for Specialist Registration - The award of a CESR signifies that a doctor has successfully demonstrated that their training, qualifications and experience are deemed equivalent to the award of a CCT.

COGPED: Committee of General Practice Education Directors.

COPMeD: Conference of Postgraduate Medical Deans.

CP Route: Combined Programme route - The process of awarding a certificate to doctors who have followed a combination of training in a PMETB approved programme (from the point of their entry to the programme to successful completion) and training/experience in posts prior to appointment which were not PMETB approved posts.

Good Medical Practice (GMP): Good Medical Practice describes what is expected of all doctors registered with the GMC.

GPCCT: (GP) Certificate of Completion of Training **–** The award of a GPCCT confirms that a doctor has satisfactorily completed a PMETB approved training programme and is eligible to become a GP. Please note that although GPCCTs are awarded, the term CCT is often used to apply to certificates issued to both specialists and GPs.

MMC: Modernising Medical Careers.

PMET: Postgraduate medical education and training.

PMETB: The Postgraduate Medical Education and Training Board.

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