RCS

ADVANCING SURGICAL STANDARDS

Annual Report 2009–2010

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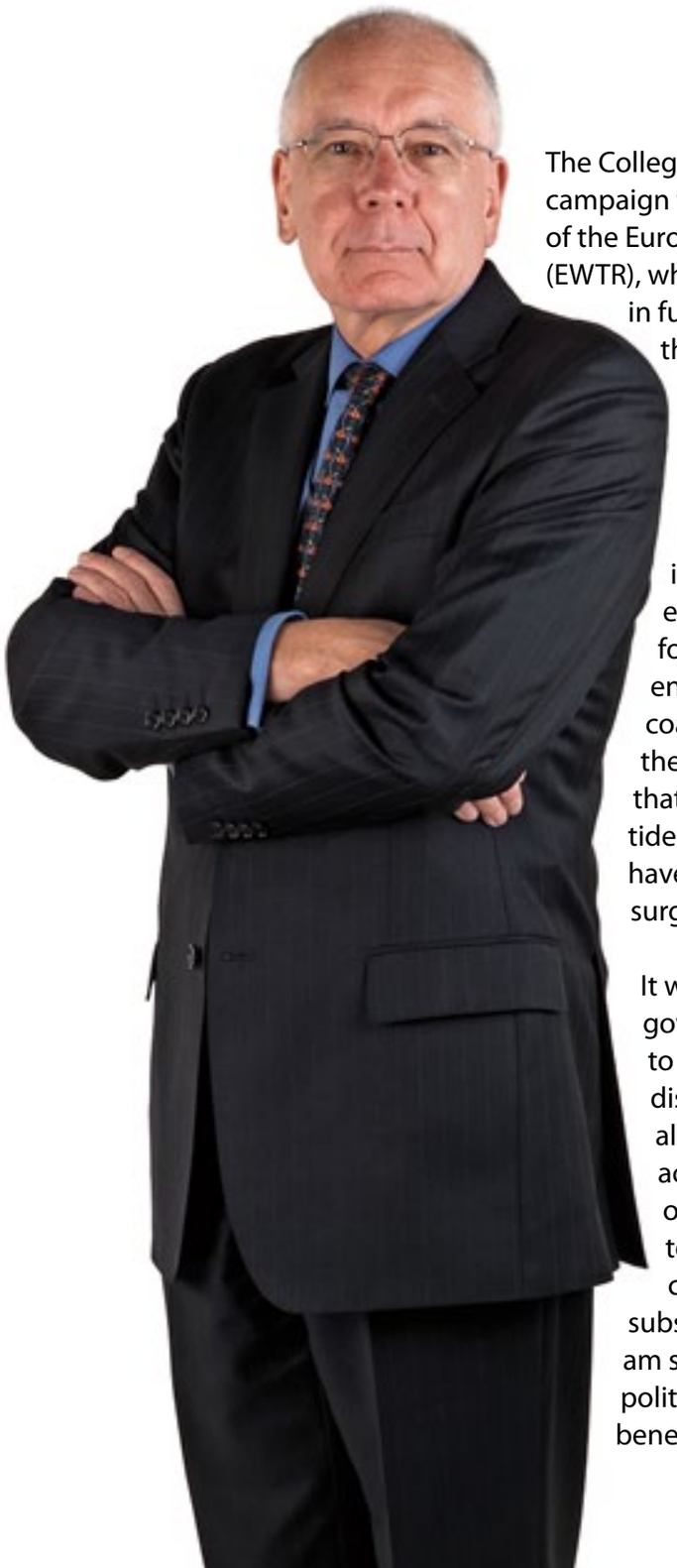
Foreword from the President



The College has remained very active in its campaign to release surgeons from the effects of the European Working Time Regulations (EWTR), which were meant to be implemented in full from 1 August 2009. We argue that the 48-hour working week for surgeons cannot be delivered in the NHS and is dangerous for patients and disastrous for training. This view is becoming more widely accepted. Both the main opposition parties included measures to deal with the effects of EWTR in their manifestos for the May general election, it was encouraging to see it addressed in the coalition agreement and to hear from the new Secretary of State for Health that he intends to act. We hope that the tide has turned on this issue, which I have described as a 'battle for the soul of surgery'.

It was also encouraging that the new government has fulfilled its promise to scrap several NHS targets that were distorting surgical practice and not allowing surgeons to treat patients according to clinical need. This was part of our manifesto that we submitted to all the political parties at their conferences in the autumn of 2009 and subsequently in the election campaign. I am satisfied that our efforts in the national political arena are producing results, to the benefit of all surgical patients.

The revalidation process, which will require doctors to demonstrate their continuing fitness to practise at least every five years in order to retain their licence, has been postponed for a year. We welcome this decision as it allows more time for piloting the standards for all branches of surgery. I am pleased to say that we have reached an agreement with the other surgical royal colleges to provide a single UK-wide portfolio and logbook, which will help surgeons to collect the evidence they need for appraisal.

Our appointment of senior surgeons as directors of professional affairs (DPAs) in each strategic health authority in England, Wales and Northern Ireland has continued and the national network is now almost complete, with specialty association regional representatives incorporated as College regional specialty professional advisors (RSPAs). Their role in providing specialty advice to NHS commissioners is growing and they are becoming increasingly influential.

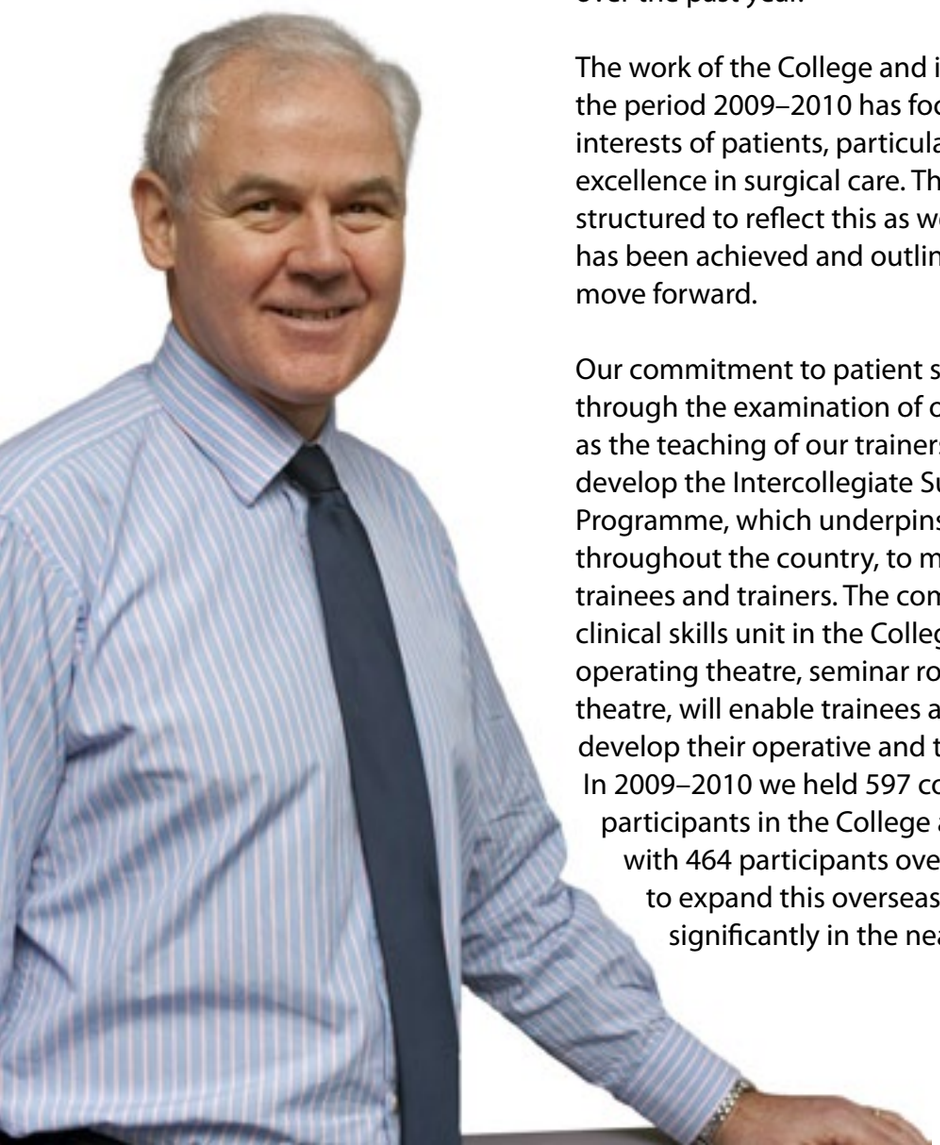
We are grateful to the Patient Liaison Group for its continued guidance to Council under the capable chairmanship of Sue Woodward. Matters such as the adverse effects of EWTR and the 'target culture' surrounding continuity of care between patients and clinicians have exercised them considerably and it is good that they have common cause with working surgeons.

The third phase of the Eagle Project, our state-of-the-art surgical skills unit occupying the fourth floor of the College, was completed in January 2010 and was opened in April by Jack Ladeveze, Chair of the Enid Linder Foundation, one of our major benefactors. This ambitious project was completed on time and within budget, to the credit of the staff members involved.

As I said last year, it is impossible in a short foreword to do justice to the many activities of the College, all in support of our strategic aim of achieving the highest standards of patient care in surgery. May I thank the very many staff members and surgeons everywhere who devote themselves to this.

John Black
President
The Royal College of Surgeons of England

Introduction from the Chief Executive



I am pleased to present my second annual report and take pride in reviewing our achievements over the past year.

The work of the College and its Council during the period 2009–2010 has focused on the interests of patients, particularly in the pursuit of excellence in surgical care. This report has been structured to reflect this as we look back on what has been achieved and outline how we intend to move forward.

Our commitment to patient safety is emphasised through the examination of our trainees as well as the teaching of our trainers. We continued to develop the Intercollegiate Surgical Curriculum Programme, which underpins surgical training throughout the country, to meet the needs of trainees and trainers. The completion of our new clinical skills unit in the College, with a 'training' operating theatre, seminar room and lecture theatre, will enable trainees and surgeons to develop their operative and teamwork skills. In 2009–2010 we held 597 courses with 8,735 participants in the College and ran 181 courses with 464 participants overseas. We intend to expand this overseas component significantly in the near future.

The work of our Patient Liaison Group (PLG) furthers the College's commitment to patient and public inclusion. The PLG has made many invaluable contributions to both government and College publications, consultations and policy initiatives during the period.

The College's pursuit of excellence in the delivery of surgical care is constant. Surgical research undertaken by our research fellows, as well as in partnership with other bodies, continued successfully throughout 2009–2010. We provided a full programme of continuing professional development and educational activities for surgeons at all levels and across all specialties, ranging from basic skills courses to advanced specialist masterclasses.

We are committed to providing public access to our College and I am pleased to report that our outstanding Hunterian Museum attracted over 49,000 visitors this year.

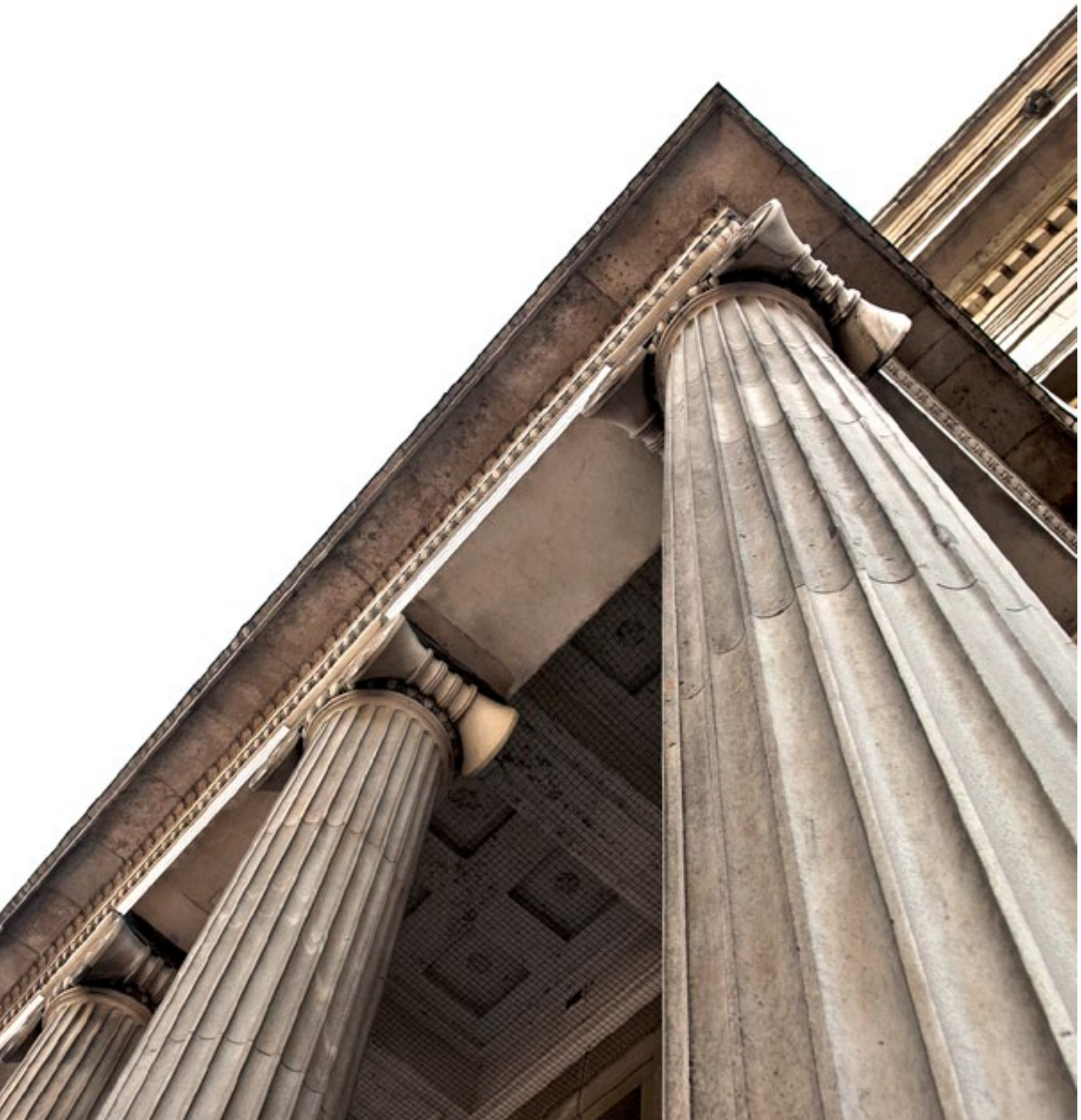
We continued to look at innovative ways to support our members and have expanded our regionally based staff in order to improve channels of communication further and thus better support our members.

The College has had to re-examine some of its work in response to the recent economic climate and this has affected some areas of College activity. However, the measures implemented are already showing positive results and I sense that this particular corner has now been turned.

In conclusion, I would like to thank all members, staff and supporters of the College for helping us achieve our objectives. I look forward to continuing to work towards achieving Council's aims for 2011–2014 so that the College can enable surgeons to achieve and maintain the highest standards of patient care and surgical practice.

Alan Bennett
Chief Executive
The Royal College of Surgeons of England

About the College



The Royal College of Surgeons of England is one of the world's leading medical institutions. Its central purpose is to enable surgeons to achieve and maintain the highest standards of surgical practice and patient care.

The College is a registered charity and has no political affiliation. It has expertise, authority and independence, and it acts entirely in the interests of patients and in support of those providing their care. The College provides strategic leadership and support to the surgical profession and influences policy making that has a direct impact on surgeons and their patients. The College works with the government and its departments and agencies, the NHS, health authorities, trusts and hospitals, a range of professional bodies, and with patients and the public to enable the delivery of the best surgical care today and in the future.

The College is governed by a Council elected by the fellows and members of the College. There are 24 elected surgical members and 2 dental surgery members. The elected Council members are the College's trustees. In addition to the trustees there are a number of members representing specific interests invited to participate in Council (although they do not have a formal vote). These include the Dean of the Faculty of General Dental Practice (UK), representatives of the nine surgical specialty associations, the College Court of Examiners, the staff and associate specialist grades, and surgeons in training. A member of the College's Patient Liaison Group also sits on Council to represent patients. The Council reflects a range of professional interests, acting on behalf of surgery in general, chaired by John Black, the President.

Promoting High Standards of Patient Care

As a College, our overarching aim is to advance surgical standards to enable individuals and surgical teams to deliver patient care to the highest possible standard.

Improving the outcomes of operations

How we deliver public benefit:
We collect the outcomes of operations to assess the quality of the surgical treatment and overall care patients receive. This will help the NHS to identify areas for improvement and see if new developments are producing positive results.

Since 2009 all NHS patients having hip or knee replacements, varicose vein surgery or groin hernia surgery are being asked about their health and quality of life before the operation, and their health and the effectiveness of the operation after surgery. This data is being collected through PROMs questionnaires. PROMS are patient-reported outcome measures. The College's Clinical Effectiveness Unit (CEU) plays a leading role in improving methods to compare outcomes reported by patients and in publishing results that are meaningful to the public, clinicians and other stakeholders.

In June 2010 the CEU together with the Association of Breast Surgery; the British Association of Plastic, Reconstructive and Aesthetic Surgeons; and the Royal College of Nursing; and on behalf of the Healthcare Quality Improvement Partnership; published the third report of the National Mastectomy and Breast Reconstruction Audit. This made a number of key recommendations aimed at improving breast cancer services in England. It was found that nine out of ten women who had a mastectomy or breast reconstruction surgery felt that they had received the right amount of information about the surgical procedure they underwent. The audit recommends that the option of breast reconstruction is discussed with all patients undergoing mastectomy, as recommended by the National Institute for Health and Clinical Excellence (NICE) in 2009.

The CEU is involved in the following national audit projects:

- patient outcomes in surgery audit comparing outcomes of elective surgery in independent sector treatment centres and the NHS
- patient-reported outcome measures after elective surgery (Department of Health PROMs programme)
- mastectomy and breast reconstruction
- oesophagogastric cancer
- liver, heart and lung transplantation
- the Craniofacial Anomalies Network (CRANE) database, which is a record of children born with a cleft lip and/or palate throughout England and Wales
- the National Joint Registry
- value of hospital episode statistics for the revalidation of clinicians

For more information on these projects see pages 78–82 of the Surgical Research Report.

Maintaining standards

The General Medical Council (GMC) is intending to introduce a new system of regulation for doctors in 2011. The new system, called revalidation, will mean that every doctor will be reviewed every five years to renew his or her licence to practise.

The College was given the responsibility of setting the standards for surgeons and we worked with the surgical specialty associations to develop these based on a common template for all doctors. Standards relating to surgery-specific activities were added, including:

- leading the theatre team
- using the World Health Organization's *Surgical Safety Checklist*
- taking part in national audits such as the central cardiac audit database

These standards were approved by the GMC in January 2010. Guidance relating to these standards was published in June 2010 to support surgeons involved in piloting revalidation. To help surgeons collect the information they need to present for revalidation the College has developed an online portfolio. Surgeons can upload documents to show how they meet the standards and make notes on what they learnt from different meetings and events. A trial portfolio was launched in November 2009 and surgeons are providing their feedback.

Reviewing surgical services

Since the establishment of the service in 1998, the College has supported over 140 hospitals in maintaining and improving surgical standards and patient care through the Invited Review Mechanism (IRM). The IRM is designed to support local review procedures by providing an independent professional review process to help trusts determine if there is a cause for concern about the performance of a surgeon or surgical unit and to make recommendations for improvement where necessary. The IRM also provides independent advice and expertise to support trusts in deciding how to structure their services for the future.

Future plans

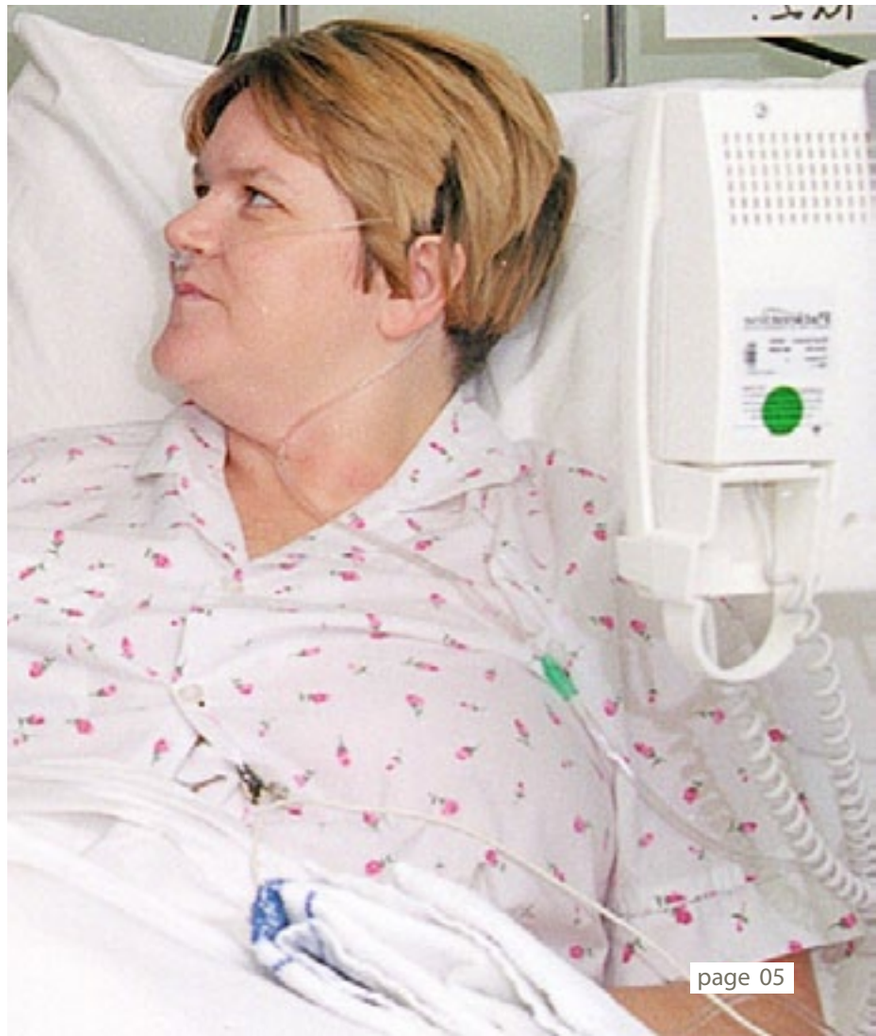
- We will continue to support trusts to deal with performance issues through the IRM.
- We will continue to collaborate with the National Patient Safety Agency and Care Quality Commission on the development of the service.

Developing regional trauma systems

For many years the College has been concerned about the quality of care provided to severely injured patients and the poor organisation of trauma services. While recognising that service reconfiguration is a highly contentious subject, we have always believed that there was evidence for reorganising trauma services. We have issued repeated calls to the government to work with us to understand these problems and to identify the most appropriate configuration of services to provide the best outcomes.

Our guidance, Regional Trauma Systems: Interim Guidance for Commissioners, was published in December 2009. The report provides commissioners with the tools to designate major trauma centres and trauma units within a specified region to create a trauma system and outlines the optimum resource requirements for delivering safe and effective trauma care.

Together with the College of Emergency Medicine and the Royal College of Nursing, we also outlined an approach on the identification and management of patients who misuse alcohol, primarily for patients who have been admitted for trauma. This highlights that in cases in which there is evidence of alcohol misuse, patients would benefit from advice on how to change their behaviour from nurses while they are in hospital for surgical treatment.



Developing paediatric surgery

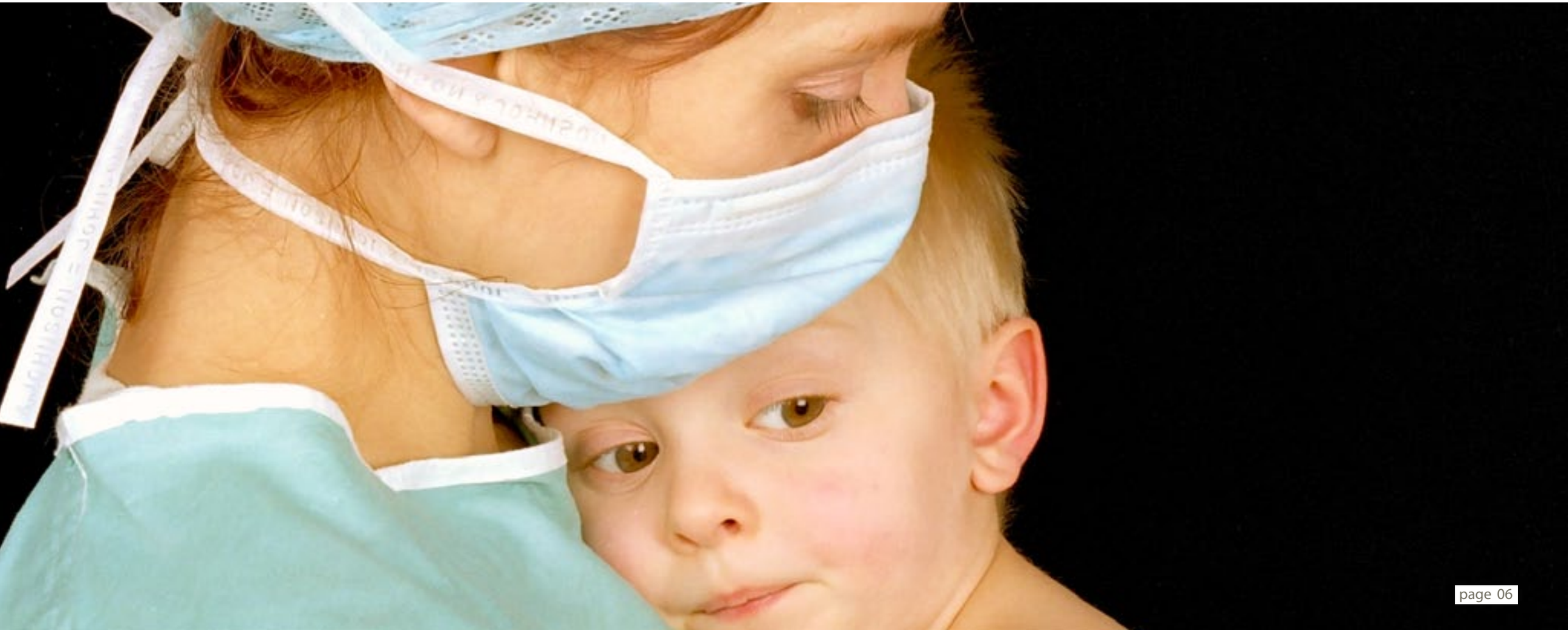
The Children's Surgical Forum produced definitive guidance for commissioners and service planners in the NHS to ensure the continued availability of high-quality general surgery for children that is easily accessible locally.

The College recognises that some reorganisation and centralisation of specialist paediatric surgical procedures may be appropriate in order to provide safe and effective care. However, we believe that any service reconfiguration should be driven by clinical evidence and we strongly oppose reconfiguration for the sake of managerial, financial or political expediency.

We have also campaigned for a flexible application of Criminal Records Bureau (CRB) checks in the interim years leading to the full implementation of the new Vetting and Barring scheme. Until recently, the time-consuming duplication of enhanced disclosure CRB checks for surgeons who wish to work short term across NHS trusts has often resulted in severely delayed or cancelled operations. We advocated a solution that will allow cross-site working for clinicians in order to ensure efficient and timely delivery of services to patients, and optimal training and continuing professional development opportunities for surgeons. We continue to press NHS Employers and the Department of Health to ensure that flexibility is implemented for CRB checks and we issued guidance for the current checking requirements.

Patient information

The College and the Department for Work and Pensions worked collaboratively to produce a series of electronic information leaflets for patients, surgeons and GPs, outlining normal progress and possible postoperative complications, and giving advice (with appropriate caveats) about returning to work. These Get Well Soon leaflets were published in July 2008. In April 2010 the electronic leaflets received over 160,000 page views. As a result of this success, a further leaflet on stress incontinence was produced by the Royal College of Obstetricians and Gynaecologists. We will be producing a further set of leaflets for other common surgical procedures.



The Patient Liaison Group

Improving standards of patient care and patient safety remains the focus of our work. The Patient Liaison Group (PLG) provides a formal mechanism for patient representation to the College and provides an active and open dialogue between surgeons and patients. The PLG is committed to achieving improvements for patients needing surgery and strives to ensure that they have access to information that is clear, honest and accurate.

During the year, the PLG worked with the College to produce a pioneering video that looks at what can go wrong in a simple operation and how to deal with problems as they arise. The PLG was also involved in the adoption by the College of the World Health Organization's *Surgical Safety Checklist*, which addresses vital safety concerns that could be overlooked during surgery. The PLG has also worked on revalidation, seeking to ensure that a core aspect of revalidation is that doctors are able to communicate fully with patients, including being responsive to feedback and complaints from patients.

Following a successful tenure as Chair of the PLG, Lesley Bentley stepped down at the end of 2009. One of the first projects the group has worked on under the new Chair, Sue Woodward, is that of the clarity of medical titles, namely the use of the title 'consultant surgeon'.

The PLG provides a direct public voice within the College and continues to stress the importance of listening to the patient, communication skills and adequate and appropriate training of surgeons. To this end the PLG is represented on Council and many of the College's internal working groups.

Leading the Profession

By influencing areas of health policy that affect the surgical profession, the College is seeking to provide surgeons with the best possible training, working conditions and facilities in order to carry out their jobs to the highest standard for the benefit of the public.

Patient safety

How we deliver public benefit:
We are working to improve standards of surgical services and the way in which they are delivered for the benefit of patients. In order to achieve high standards of patient care, we believe that surgeons should have the flexibility of extending their working hours and not be restricted to the 48-hour week imposed by European Working Time Regulations (EWTR). The restriction in working hours is affecting patient safety by increasing handovers between teams and reducing levels of cover.

We continue to campaign vigorously for a sectoral opt-out from EWTR, which currently limit surgeons' working hours to 48 per week. Our survey of surgeons in October 2009 demonstrated that around two-thirds of surgeons were working more than the 48-hour working week in order to maintain the current level of service and access for all patients. It also found that a significant reduction in working hours would have a considerable impact on training. Surgeons reported that the shift system is significantly more tiring than the on-call system it replaces. In addition, there has been an increase in handovers, with doctors unable to follow their patients through surgical treatment.

The College is therefore calling for all surgeons, including those in training, to be exempt from the restrictions of EWTR. This would offer them the flexibility of extending their working hours up to a maximum of 65 hours per week, with appropriate rest breaks, so that hospitals are staffed safely to provide high-quality care for all patients. Other services, such as the armed forces and police, have been granted exemption from the working restrictions, as have industries as diverse as deep-sea fishing and journalism. We would like to see this exemption granted to surgeons and we were delighted to hear the new government's pledge in May 2010 to limit the application of EWTR in the UK.

John Black, the President, chairs the National Patient Safety Agency's (NPSA's) Clinical Board for Surgical Safety. This board oversees the development of surgical rapid-response reports, which advise clinicians on best clinical practice, following alerts issued through the National Reporting and Learning Service. For example, in April 2010 a rapid-response

report was issued on checking pregnancy before surgery and individual trusts are required to keep the NPSA informed of how this is being implemented.

In July 2009 we launched a training film, The Journey, which has been designed for use by different members of the surgical team. It examines the way in which basic errors can cascade into serious safety incidents and emphasises the importance of systemic good communication between different members of the team. The launch of this film was attended by MPs, representatives of patient safety organisations and other stakeholders. Attendees visited the College's new training facility, where the College is already using this film as part of its pilot 'team theatre skills' course.

We have endorsed the World Health Organization's *Surgical Safety Checklist* and called for its full implementation across the health service. The checklist identifies three phases of an operation, requiring the surgical team to confirm that each task has been completed before proceeding to the next phase. We have been promoting this checklist to our members and in December 2009 we held a joint event with Patient Safety First to launched a toolkit to help clinicians implement the checklist.

We responded to the Health Select Committee's report on patient safety, supporting the recommendations to increase data collection within the NHS through the National Reporting and Learning System and to undertake root-cause analysis. We agreed that the introduction of new technologies is vitally important for surgery in the NHS and the College has a key role to play in training surgeons to use these technologies appropriately, safely and effectively.

In autumn 2009, in anticipation of a general election, we produced our first manifesto, Surgery in Safe Hands: Priorities and Policies 2010. This set out our call for action on key issues around three main themes: delivering for patients, supporting and developing the profession, and advancing the frontiers of medical care. It was produced to influence the health policies of the main political parties. The manifesto was launched at the political party conferences and gave us the starting point for our meetings, provoking debate and comment.

We took the theme of patient safety to the 2009 party conferences and partnered with the Royal College of Midwives and the Specialised Healthcare Alliance. At the fringe event at the Liberal Democrats party conference, 'Are patients safe in the Lib Dems' hands?', Sandra Gidley, Shadow Health Minister, spoke and Sal Brinton, the Liberal Democrats Prospective Parliamentary Candidate (PPC) for Watford, chaired the debate. For our event at the Labour Party conference Mike O'Brien, Shadow Health Minister, spoke with Gaby Hinsliff, Political Editor of *The Observer*, as chair. Rounding off the conference season at the Conservative Party conference, Anne Milton, Shadow Health Minister, spoke at 'Are patients safe in the Conservatives' hands?', with Margot James, PPC for Stourbridge and Conservative Party Vice-chair, chairing the event. The College was represented on the panel at our events by John Black, the President, or Alison Cook, Director of Policy and Communications, and joined by speakers from our two partner organisations.

Influencing policy

The College continues to work to influence areas of health policy to ensure the highest standards of care for patients are delivered. Throughout the year we have made our position, views and opinions on aspects of surgery clear to a range of stakeholders who have an impact on surgery. This has included meetings with government ministers, the Care Quality Commission, the National Institute for Health and Clinical Excellence and the General Medical Council. John Black, the President, has been very vocal on our concerns surrounding the impact of the new working hours on patient safety. Together with senior Council members, he met with the previous government and the new coalition government, made a number of media appearances and voiced our concerns at political party conferences. John Black also chairs the National Patient Safety Agency Clinical Board for Surgical Safety and is a board member of Medical Education England.

In April 2010 the College held a seminar on live surgery to inform the development of College policy. Live broadcasts of surgical procedures have become increasingly common, not only at medical or surgical conferences to professional audiences but also more recently on mainstream television. The seminar examined the various strands of the debate with a range of expert speakers and a selected audience including clinicians, policy makers and others with an interest in the topic. There was general consensus that with the appropriate guidelines, surgery being transmitted live for educational purposes to an audience of professionals is valuable. This issue is currently being debated by the College Council.

Another area of College policy discussed during the year was the importance of continuity of care. We believe that patients should be assured of continuity of care throughout their treatment and should meet and have ready access to the consultant with overall clinical responsibility for their care.

In conjunction with the Association of Laparoscopic Surgeons, the Association of Upper Gastrointestinal Surgeons and the British Obesity and Metabolic Surgery Society, we held a policy seminar to examine the provision of bariatric surgery in the UK and found that access to NHS weight loss surgery is dependent on geographical location. We are calling for consistency and transparency across the NHS so that patients understand their entitlements and doctors can treat all patients equally.

We also invited the three main political parties to set out their policy on the NHS and what it would mean for surgery in our membership magazine, the Bulletin, ahead of the general election.

Supporting Surgeons through Education and Training

Surgical education is crucial for the advancement of patient safety and care. The College is the leading provider of postgraduate surgical education in the UK. We have developed one of the most advanced specialised teaching facilities in the world. These facilities are an important national resource from which to pilot, quality-assure and deliver educational innovation.

Surgical training

The recently completed Education Centre houses state-of-the-art technology for training surgeons and other professionals who work in theatres. The centre demonstrates our aspiration to remain at the forefront of surgical education and enables the College to make the most of technological innovations in a learning environments. The Education Centre delivers the infrastructure and facilities needed to:

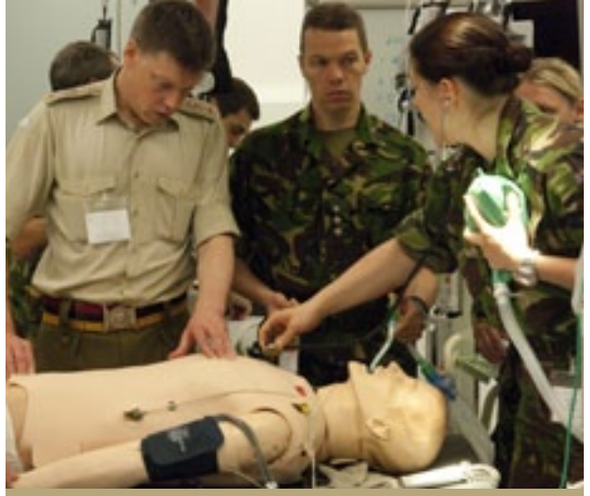
- deliver a range of surgical anatomy and skills training
- teach decision making and team skills
- evaluate new surgical techniques
- develop new educational techniques and use technology for on-site and remote learning.

The Wolfson Surgical Skills Centre is the largest cadaveric dissection workshop in the UK. This facility enables surgeons to develop their practical knowledge of surgical anatomy and undertake skills-based training. The Education Centre also houses a skills area that uses models and simulation to deliver essential surgical skills. A minimally invasive surgery suite provides opportunities to develop and enhance skills in keyhole surgery as an essential part of the surgical curriculum.

The team skills training theatre is equipped with a wireless mannequin and fully integrated multimedia technology that provides simulation-based training to develop team working. We use video debrief techniques to enhance the learning experience and provide teams with an opportunity to reflect on and develop their communication skills for the benefit of their patients.

The final phase of this education project was the building of four seminar rooms and a lecture theatre for 50 participants. This was formally opened by Jack and Audrey Ladeveze of the Enid Linder Foundation on 21 April 2010.

The Education Centre offers a wide range of courses for surgeons and the wider surgical team from foundation to consultant level across all surgical specialties. These are developed by appointed surgical tutors in conjunction with specialty associations and support the curricula for surgical trainees' and consultants' continuing professional development. Our courses are also offered on a regional basis. In 2009–2010 we held 138 courses with 2,754 participants in the College and ran 534 courses with 7,744 participants nationwide and overseas.



I was very impressed with the integration of the team concept. Groups of four to six were composed of a mix of general and specialty surgeons, orthopaedic surgeons, emergency physicians and anaesthetists from all three service branches who will be deploying to Afghanistan. As an observer and participant, it was very interesting to see the rapid improvement in cohesiveness that this exercise generated and I suspect that this will serve as excellent preparation as these medics prepare to deploy.

Captain Burkhardt
Military Operational Surgical Training course participant

We are pleased to continue our support of the *Military Operational Surgical Training* course. It is a surgically led course that prepares multidisciplinary clinical teams for deployment to operational environments. The course utilises all areas of the Education Centre and is an example of how the College can effectively support surgical training through a range of teaching environments

We have successfully developed the Patient Safety in Theatre Teams course using the team skills training theatre and the Legal Aspects of Surgical Practice course that equips surgeons to tackle the many medico-legal issues facing the profession today.

Continuous improvement is also a feature of the skills and specialty curriculum and we have developed a follow-on advanced laparoscopic skills training course. To support the shortage of trained surgeons available to carry out bariatric surgery and implement the 2006 NICE guidelines on weight-loss surgery, the College has developed a two-day skills course in bariatric surgical techniques and patient management.

We continue to share our expertise with surgical communities across the world. In particular, *Care of the Critically Ill Surgical Patient*®, *Training the Trainers* and basic surgical skills courses are delivered internationally in countries including Germany, Norway, Sweden, Egypt, Jordan, Tanzania and Australia.

Future plans

- We will develop courses to support new procedures and technology.
- We will develop courses to support patient safety.

The Joint Committee on Surgical Training

The Joint Committee on Surgical Training (JCST) is an advisory body to the four surgical royal colleges and surgical specialty associations of the UK and Ireland for all matters relating to surgical training. The JCST enrols surgical trainees, monitors their progress and makes recommendations as to when they are ready for the Certificate of Completion of Training (CCT) (awarded to trainees in the UK following completion of a recognised training pathway). It also evaluates applications for specialist registration from surgeons who do not have the CCT but who have acquired equivalent training, qualifications or experience.

Over the past year, the JCST developed a 'good practice toolkit' for the selection of surgical trainees, providing good practice tools, models and techniques for those responsible for selection to use. It also conducted a survey of all surgical trainees at the end of their surgical placements. This asked trainees to evaluate and comment on the quality of the placement against JCST training standards and their engagement with the curriculum. The findings were reported to, and acted on by, the schools of surgery (the bodies responsible for training placements).

In plastic surgery, one of the first surgical specialties to adopt national selection procedures, we have developed a number of methods that are described in the toolkit and find the descriptions of methods used by other colleagues extremely helpful in guiding us as we try to improve on our overall selection package. We believe that we have already achieved a much more transparent and fair system for selection and that reliability and validity can only continue to increase as work continues to be done.

Eric Freedlander
Former Chair of the plastic surgery specialist advisory committee
President of the British Association of Plastic, Reconstructive and Aesthetic Surgeons

Participating in the advanced laparoscopic/bariatric surgery course helped prepare me for work as a specialist registrar (SpR) in a busy bariatric unit. I gained valuable insight into the surgical techniques used in bariatric surgery and the logistics involved in setting up an obesity surgery service. The course provided an overview of the problems obesity holds for the health service and the challenges that this patient group presents.

John Loy
SpR in bariatric surgery, Musgrove Park Hospital, Taunton

The findings were also considered by the specialist advisory committees, who oversee the quality of training in individual surgical specialties. By working with the schools of surgery on identifying and addressing where training falls below the established standards we improve the quality of surgical training to the benefit of patients.

The Intercollegiate Surgical Curriculum Programme (ISCP) was introduced in August 2007 for the nine surgical specialties. It defines the standards for progression for trainees and incorporates assessments of performance in the workplace. It is supported by a web-based online portfolio that stores trainees' electronic logbooks and learning agreements, which support training. The ISCP facilitates trainees' annual review process and the award of the CCT. We have upgraded the ISCP web pages so that trainees benefit from improvements such as better logbook navigation, searching, personalisation, registration, and evidence collection and validation. Our core surgical curricula have been rewritten to accommodate all the different types of training across the county.

The revised membership examination

The purpose of the MRCS examination is to determine whether trainees have acquired the knowledge, skills and attributes required for the completion of core training in surgery and, for trainees following the ISCP, to determine their ability to progress to higher specialist training in surgery. The format of the MRCS for trainees was revised in October 2008 to reflect the new surgical training requirements introduced in August 2007. Non-medical examiners sit alongside medical examiners to assess candidates' communications skills through a practical role-play situation. This involves an actor role-playing with a candidate under observation by both lay and clinical examiners and forms part of the objective structured clinical examination (OSCE). Other core elements include the assessment of anatomy and surgical pathology, surgical skills and patient safety, applied surgical science and critical care, clinical skills, communications skills, organisation and planning, decision making and judgement. The OSCE was revised during the year to have more basic science and clinical components.

Supporting aspiring surgeons

The College provides advice and guidance to surgeons and aspiring surgeons at all stages of their careers. In October 2009 we launched a surgical careers website with careers stories to provide career information to medical students, surgical trainees and surgeons.

Over the past year we organised 40 careers events, workshops and presentations aimed at informing students of the skills and knowledge required to become a surgeon. We are producing a careers support pack for surgical societies at universities to organise their own careers fairs for sixth-form students and for trainees to organise events at hospitals.
In April 2010 we ran our annual health and medicine careers fair for 120 year-10 students to promote careers in medicine including surgery. We have also set up a new affiliates' scheme for medical or dental students studying at UK universities or for foundation and core surgical or dental trainees who have not yet passed their MRCS or MJDF examination. This scheme includes careers support and advice, career development events and access to our library services and selected e-journals.

The Women in Surgery (WinS) group provides advice, guidance and support for women already in surgery or considering it as a profession. Diane Abbott MP addressed the annual conference in 2009.

In 2009–2010, 60.5% of trainees chose to take their MRCS examination at this College, a significant increase compared with the previous year. The MRCS is scrutinised by all the surgical royal colleges to ensure that it tests the skills and aspects of knowledge set out in the syllabus in a way that is fair to the candidate and ensures that standards are maintained. We continue to focus on improving the way exams are run and delivered at the College and we have improved the online examination entry system for candidates. We have opened new exams centres for the MRCS in India and Bangladesh.

I was appointed as a lay examiner by the College to examine candidates' communication skills as part of the MRCS. I was selected through an interview process and received a full day of specific communication skills training as well as general OSCE examiner training. It is so important to have lay input in assessing communication skills; after all, who is better placed to judge a professional's ability to communicate with a patient than the patients themselves? I commend the Royal College of Surgeons for appointing lay examiners and hope that other medical royal colleges follow this example.

Rosemary Harris
Lay examiner for MRCS part B OSCE since 2008

I found attending the WinS conference very helpful. Having the opportunity to hear from female surgeons about the issues they faced and how they tackled these has given me the confidence to accomplish my career goals. The speakers were very inspiring, particularly Diane Abbott MP, who talked through her personal career experiences. It is reassuring to know that there is a WinS network to which I can go for advice, guidance and support.

Kirsty Lloyd
Foundation doctor

Library and information services

The College library provides fellows, members, affiliates and examination candidates with learning resources to support their training, research, professional development and clinical practice. It has an unrivalled collection of historical and contemporary material focusing on surgical, dental and medically related literature, dating from the late 15th century onward, backed up by an experienced team with specialised knowledge and training, who can answer queries and provide support.

We are very grateful to the Frances and Augustus Newman Foundation, which has provided grants to the library over many years to enable the implementation of vital systems needed to develop digital services and deliver e-journal access. We hope to be able to increase the number of e-journals and to pilot e-books in 2011.

The Wellcome Trust's Research Resources in Medical History scheme has enabled us to catalogue our printed monograph collection from 1800–1850. The collection's physical condition is poor, underlining the importance of the library's Adopt a Book scheme, which is vital to our ongoing conservation work.

I have been volunteering in the archives for the past year. I decided to volunteer here because, as a holder of a history degree, working closely with historical documents is both relevant to my personal interests and gives me experience that will be beneficial to me in my future career prospects.

Margaret Hoopes
Archives volunteer

We are pleased to report that a further grant was awarded by the Wellcome Trust in January 2010 to catalogue the pre-1800 monographs.

The College archives has developed a thriving volunteer programme that is of great benefit to us and our users by allowing us to undertake work that we would ordinarily be unable to achieve. Volunteers gain valuable experience with us and we are proud to be able to help them to learn and improve their skills and historical knowledge, and prepare them for future work in the archives sector.

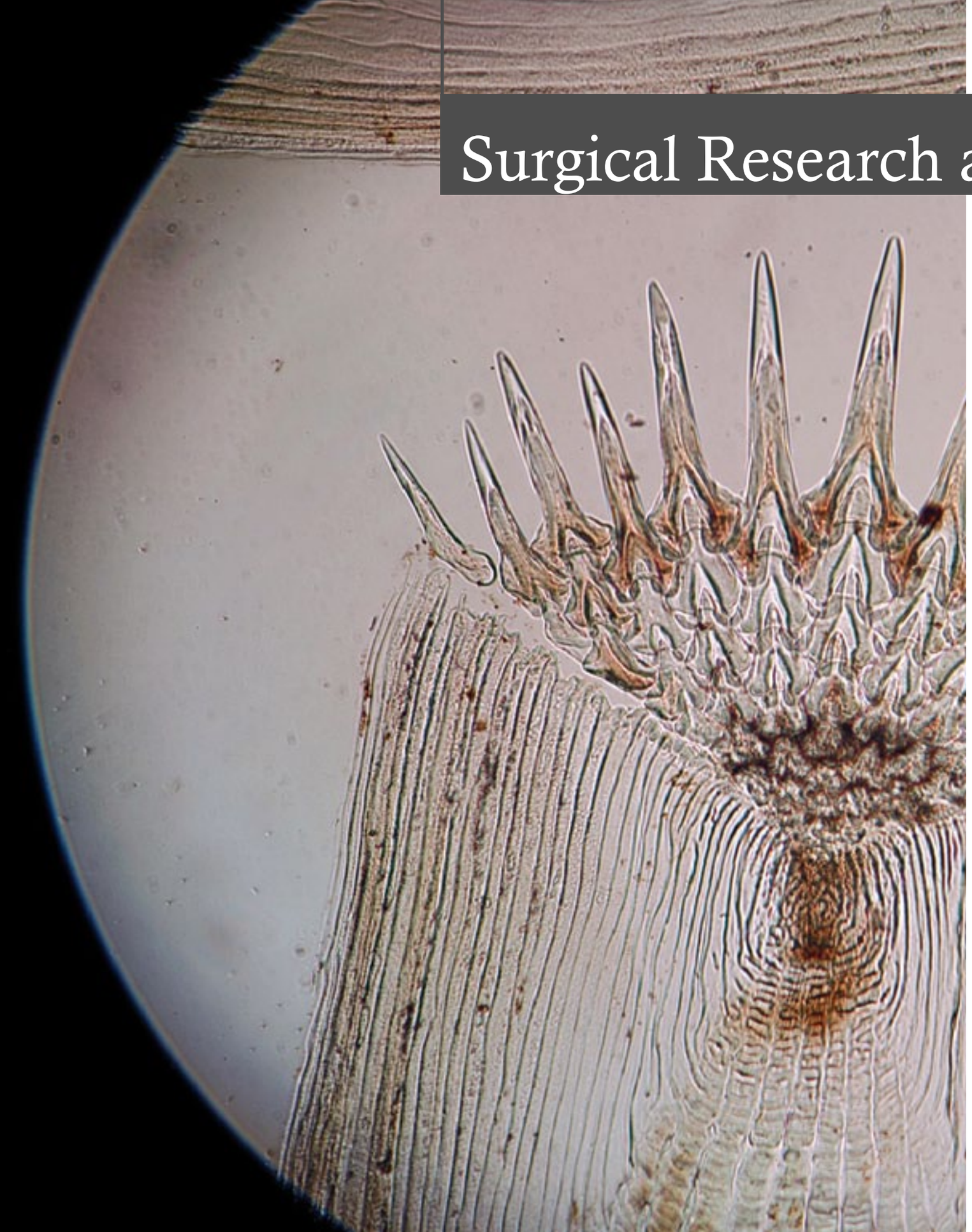
I'm a PhD student at the Wellcome Centre for the History of Medicine, University College London. My thesis looks at ovariotomy, an operation popularised during the second half of the 19th century that involved the removal of one or both ovaries. The collections at the College library are indispensable to my work.

Sally Frampton
PhD student, Wellcome Centre for the History of Medicine, University College London

Future plans

- We aim to increase the number of e-journals with 90% of current journals online and an e-book collection so that we can provide a 21st-century digital library service in support of our members.
- We will seek funding to enable us to catalogue the print collections online back to 1700 and to catalogue the remaining 50% of the deposited archives and manuscripts not yet online.
- We will continue to be responsible for the development and maintenance of NHS Evidence – surgery, anaesthesia, perioperative and critical care for NICE.

Surgical Research and New Techniques



Surgical research enables the development of procedures and techniques and helps to develop an understanding of the science behind surgery. Surgery is a key element of treatment for a third of all patients admitted to hospital. For many cancers, surgery helps more patients than any other type of treatment. Surgery-related research is grossly underfunded and we would like to see a significant increase in the proportion of medical research funding allocated to surgical research.

How we deliver public benefit:
Surgical research has continued to be a focus of the College's work. We have a central role in supporting the surgical community to identify and highlight innovative practice and promote its evidence base and widespread adoption.

Our research fellowship scheme enables surgeons to carry out important research projects on any condition related to an aspect of surgery. This scheme has allowed many surgical trainees to learn the basics of research and has encouraged them to pursue research in their chosen surgical specialty. In 2009, 23 research fellowships were awarded. This scheme relies on voluntary donations from individuals, trusts and legacies and we are very grateful to all our supporters for helping to fund these important research projects.

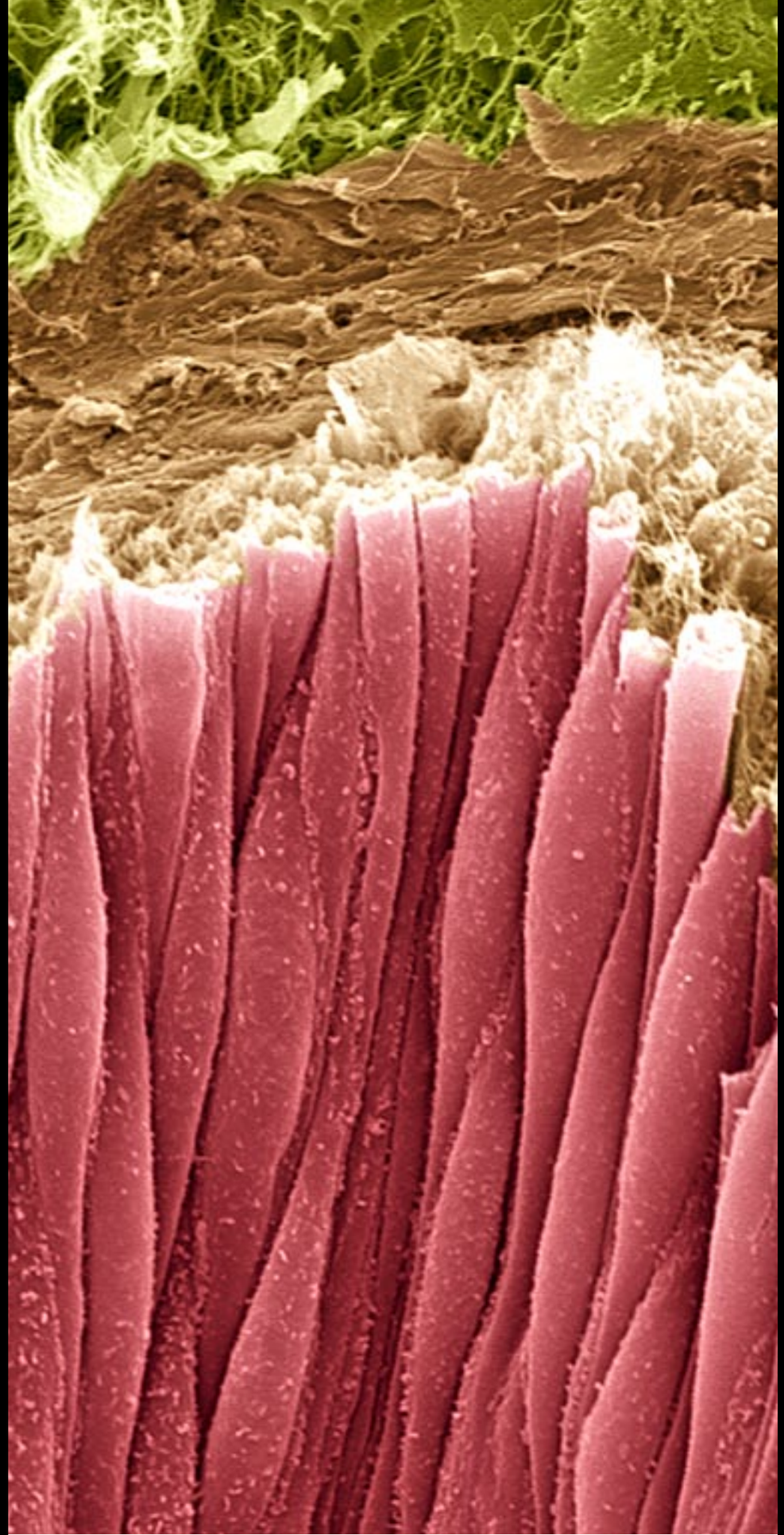
Future plans

- We will work to increase research funding for evaluating surgical interventions, procedures and techniques.
- We will develop awareness and the practice of evidence-based surgery within the surgical community.

Reducing sepsis in surgical patients

Abeed Chowdhury
Division of Gastrointestinal Surgery,
Nottingham University Hospitals
NHS Trust
Funded by the Frances and
Augustus Newman Foundation

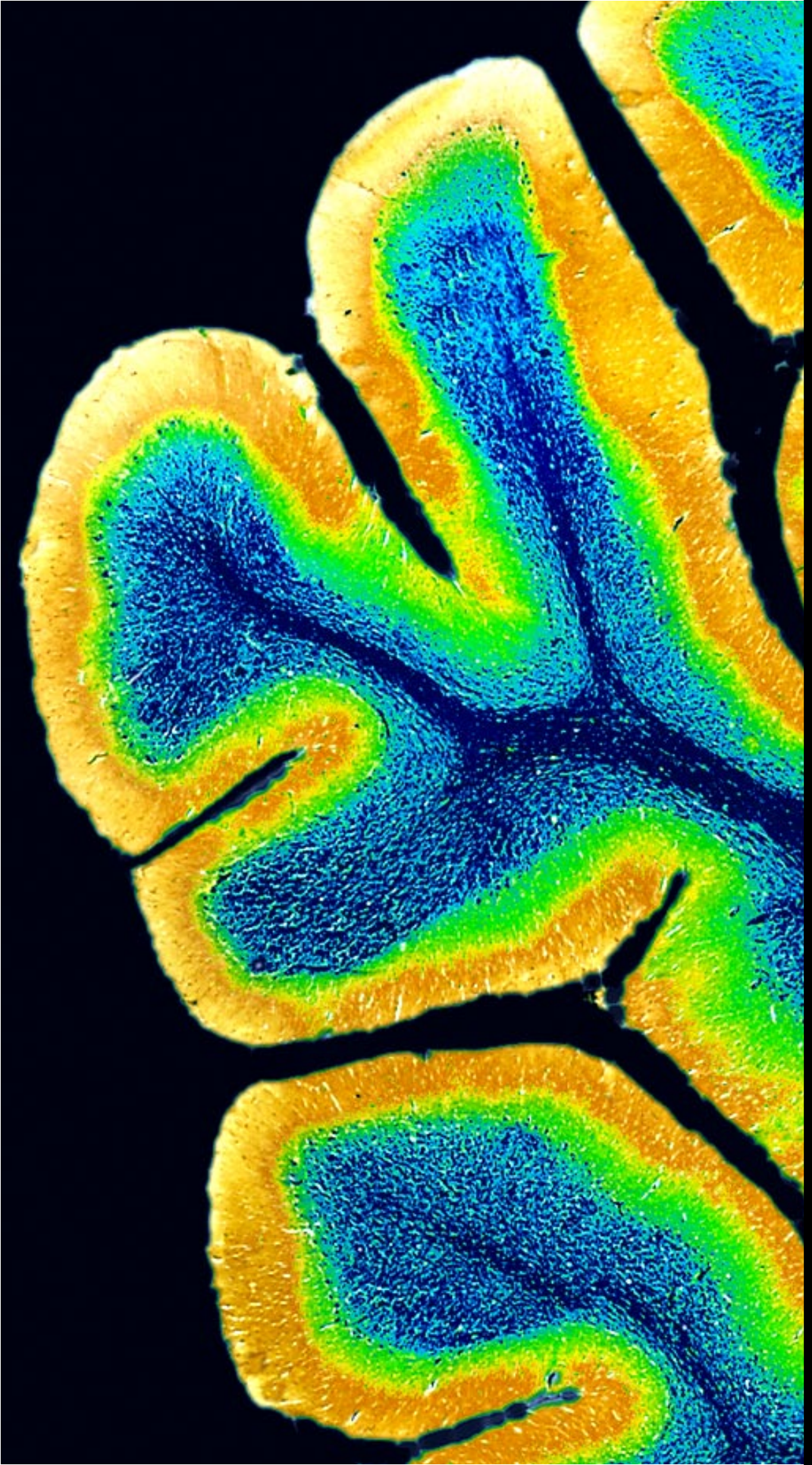
Infection in patients undergoing surgery continues to be a major cause of morbidity, with breakdown in the gut barrier and immune dysfunction thought to be principal aetiological factors. Bacteria use signalling molecules to communicate and coordinate infective behaviour. We have demonstrated that these molecules also have unfavourable effects on immune cells. We propose that by furthering our understanding of the relationship between infection and bacterial signalling molecules we will be able to develop strategies to disrupt bacterial communication and decrease the consequences of infection in surgical patients.



Rectal cancer: surgical timing after radiotherapy

Jessica Evans
Department of Colorectal Surgery
and Department of Radiology,
Croydon University Hospital
Funded by the Freemasons Grand
Lodge 250th Anniversary Fund

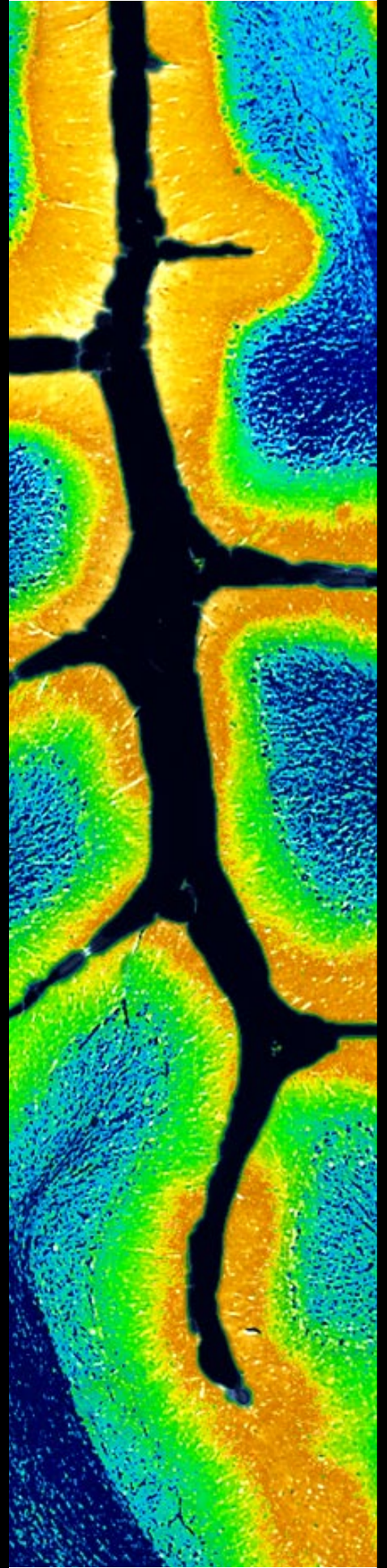
Approximately 14,000 new patients in the UK are diagnosed with rectal cancer each year. Prior to surgery, radiotherapy is frequently used to shrink the cancer, to allow complete removal and therefore reduce the chance of recurrence. Reduction in tumour size also facilitates surgery where the anal sphincter is preserved and a stoma avoided. Therefore, the ideal time to operate is when the maximum amount of shrinkage has occurred. Radiotherapy effects are time dependent; however, the optimum time to operate following radiotherapy is unknown. Identifying when shrinkage is greatest can reduce the number of patients requiring a stoma and also those suffering recurrence.



Predicting rupture of abdominal aortic aneurysms

Amir Malkawi
Department of Vascular Surgery, St George's Healthcare NHS Trust, London
Funded by the Dunhill Medical Trust

Abdominal aortic aneurysms (AAAs) are a swelling of the main artery in the abdomen. AAA mainly affects patients over 60 and, due to rupturing, causes around 10,000 deaths annually in the UK. Unfortunately, its incidence is increasing. Pressure distribution within AAA contributes to growth and rupture but we are currently unable to predict reliably when the rupture will occur. This research project is using engineering technology to obtain a pressure map for each aneurysm and take samples from high and low stress regions during surgery to investigate genetic changes. This will improve our knowledge and allow better rupture prediction for individual patients so that treatment can be given before the aneurysm ruptures and a high-risk emergency repair is needed.



Improving acceptance of organ transplantations

Fadi Issa
Transplantation Research Immunology Group, Nuffield Department of Surgery, University of Oxford
Funded by the Dunhill Medical Trust

Transplantation is the most effective treatment for irreversible organ failure. However, although outcomes have been improving, organ rejection remains a major risk. Organ acceptance is currently achieved with powerful immunosuppressive drugs, which have serious side effects such as kidney damage, serious infections and cancer development. The ideal solution is to control the immune response only to the transplanted tissue so immunosuppressants are not needed. The immune system normally controls unwanted immune responses with cells termed 'T cells' (Treg), which may be key in controlling the immune response to a transplant and are therefore a highly promising therapy.

Studying immune rejection and testing potential therapies requires a model that closely mimics rejection in humans. This research has developed a successful animal model and shown that Treg therapy may significantly prolong the survival of a skin transplant. This research is now looking at refining the model so that this therapy could be used to help improve the success of human transplantations.

The National College

A focus of the College's work is providing advice and support to surgeons on professional issues and monitoring the delivery of training in the workplace to ensure the highest standards of patient care.

Supporting surgeons at work

During the year, John Black, the President, visited a number of hospitals around the country, learning at first hand the issues affecting surgeons and the care of their patients, and hearing about local innovations to improve surgical services.

We are currently implementing a regional infrastructure to provide surgeons with advice and support on professional matters and service issues. This is a joint initiative between the College and the specialty associations. The structure is parallel to, but separate from, the schools of surgery, which deal with surgical training. It is mapped to strategic health authority boundaries and to the devolved nations of Wales and Northern Ireland. It consists of a professional affairs board led by a director for professional affairs (DPA) and nine regional specialty professional advisors (RSPAs). DPAs are now in place in nine of the ten strategic health authority regions in England as well as in Wales.

The College's initiative to develop strong regional professional leadership has provided an opportunity not only to increase its reach and influence but also its accessibility for fellows and members. We keep fellows and members in the loop by distributing regular newsletters, which because they come from a local surgeon who is well known to colleagues, will have information tailored to the local constituency and be more relevant.

Stan Silverman
Director of Professional Affairs, West Midlands

Future plans

- We will continue to develop the remit of RSPAs and provide an induction and training programme.
- We will have all DPAs and RSPAs in post across England, Wales and Northern Ireland by the end of 2010.

The College Museums

The Hunterian Museum

The Hunterian Museum spans four centuries of surgery. An accredited public museum, it offers free admission to permanent and changing exhibitions including over 3,000 anatomical and pathological preparations owned by the founder of scientific surgery, John Hunter (1728–1793).

The museum attracted 49,857 visitors in 2009–2010, an increase of 4,597 visitors from 2008–2009. A total of 102 volunteers, including over 60 surgeons and surgical trainees, supported museum staff by providing front-of-house services such as tours and talks for visitors, assisting with events or helping with the care of collections. During the year, 510 public events were delivered including school visits, family workshops and public talks.

In autumn 2009 the museum staged an exhibition on Sci-Fi Surgery: Medical Robots, which explored the world of medical robotics. This included the pioneering Probot, a robot designed in 1991 to aid prostate gland surgery, and Freehand, a robotic camera holder for keyhole surgery, as well as mini-robots designed to make their own way around the inside of the human body. Over 300 people attended film screenings and discussions around the exhibition.

With funding from the Wellcome Trust, an exhibition on Narrative Remains was introduced. This looked at some of John Hunter's anatomical specimens and the exhibition revealed the hidden histories of patients such as the Bishop of Durham and Mary Hunt, a servant.

An exhibition entitled Curious: The craft of microscopy was launched in February 2010 and included large-scale photographic prints of Victorian microscopic slides alongside microscopes from this period. We also staged an exhibition of surgical instruments, drawing on the rich historical collections of the Hunterian Museum and bringing together the expertise of surgeons, historians, and instrument designers and manufacturers.

The Hunterian Museum worked with 11 members of the Over 60s Club at the Mary Ward Centre in Queen Square, London, on the Medicine at the Movies project. This gave older learners from the local community a chance to discover how to make a film in less than 10 weeks.

In May 2010 the Hunterian Museum took part in the Museums at Night festival in London, hosting an event entitled *All Stitched Up*, in which medical professionals and knitters were brought together to swap their stitching skills.

At the Hunterian Museum in London last week I came across a small but poignant exhibit about cancer surgery. There was a photograph of an artwork by Wendy Jobber, a textile artist who had a mastectomy as well as chemotherapy. She used her creativity and humour as a way of coming to terms with what happened to her – she described the process of making the textile as 'cathartic'. While she was recovering from her surgery, she began sketching up ideas and then, while she was going through chemotherapy, she began to stitch it. The picture is a mosaic of lots of different chests, some big, some small, some lopsided and some with breasts missing. I don't know Wendy but I like to imagine the comfort she gained through her sewing and the gentle pleasure she must have felt as she made other patients and staff 'look and smile'. When I looked in the mirror this morning, I could have cried. But then I thought about Wendy's textile and I felt so much better. I felt acknowledged.

Kelly Stevens
Breast cancer patient

There were so many different learning activities within the Medicine at the Movies project, all of them fascinating and stretching. We began to look at the museum and its exhibits in a new light and learned from the other members of the group in how many different ways one can perceive the same object. We learnt how to operate a flip camera and how to use a storyboard to lay out our ideas. We learnt how to use dialogue, sound effects and music in film. Finally, and perhaps most challenging of all, we learnt how to edit our material to make a finished product.

My next goal is to use the technical filming and editing skills I acquired on the project to make a short film (or even a series of films!) about my family history.

This project was truly a life-enhancing experience that introduced me to new technologies and that in turn has opened up new horizons. I'm very grateful to have had the chance to participate in the project and for the wonderful guidance and stimulating input we received from our facilitators and from all those who participated in the project.

Harry Bridgman
Medicine in the Movies project participant

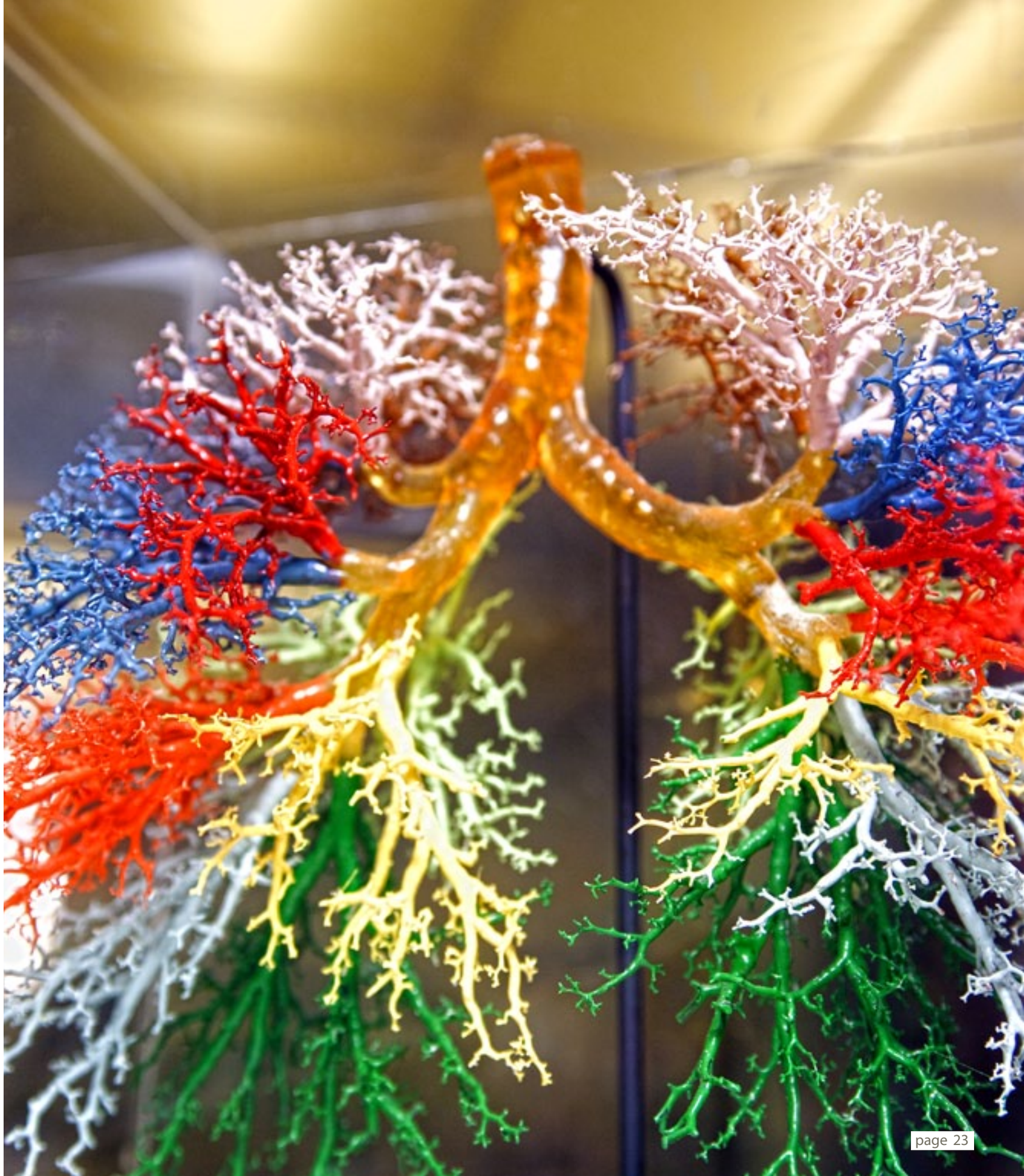
The Wellcome Museum of Anatomy and Pathology

The Wellcome Museum contains a modern anatomical and pathological teaching collection and is used to support the education, training and examination of surgeons. The collection comprises more than 800 prosections demonstrating human anatomy and over 2,000 preparations demonstrating all the important branches of surgical pathology. It is open to qualified practitioners and students on recognised courses in medicine, nursing and allied health subjects, and related scientific or technical subjects.

With funding from the London Deanery, the museum was refurbished and new specimens were provided. There were 5,536 visitors in 2009–2010 compared with 3,889 the previous year. The museum will be used by trainees in the London Deanery as part of their core surgical anatomy training.

Future plans

- We will continue to develop the Wellcome Museum's facilities and collection to support the educational needs of current and trainee surgeons, and other medical professionals.



The Dental Faculties

The dental faculties at the College aim to improve the standard of care delivered to dental patients in the community through standard setting, postgraduate training and assessment, education and research.

The Faculty of Dental Surgery

The Faculty of Dental Surgery (FDS) provides leadership and support to its fellows and members and also to trainees of all specialties, including colleagues practising in the community dental service. Working with Medical Education England and the Dental Programme Board, it provides guidance on workforce supply, dental skills mix, dental needs, dental specialties and oral surgery.

The Diploma of Membership of the Joint Dental Faculties of The Royal College of Surgeons of England (MJDF RCS Eng) recognises the successful acquisition of knowledge and skills after completion of a two-year foundation programme. Over 1,000 candidates took this exam during 2009–2010. The diploma in orthodontic therapy for dental care professionals continued to run in Leeds and South Wales. The FDS introduced a new oral surgery intercollegiate fellowship examination.

The Faculty continued to run the examinations for dental specialty memberships on behalf of the English and Glasgow surgical royal colleges. We also began to develop a new oral surgery intercollegiate fellowship examination.

The FDS, in collaboration with the Faculty of General Dental Practice (UK) (FGDP(UK)), the Department of Health and other medical royal colleges, continued its e-learning project for postgraduates that encompasses the UK dental foundation curriculum and provides educational support for the first two years after graduation from the Bachelor of Dental Surgery.

The exchange scheme for dentistry provides opportunities for overseas dentists to attend training courses in the UK and the FDS continued to administer this programme.

FDS research awards 2010

The 2010 FDS research award was presented to Rishma Shah, Lecturer at the University College London Eastman Dental Institute. The Faculty awarded four research grants including one to Ian Needleman for his work on the impact of hospitalisation on oral health.

FDS selected its first recipient of the joint FDS–Wellcome Trust research fellowship during the year. Andrew Schache, based at the University of Liverpool, will undertake a PhD during his fellowship and his project title is 'The role of human papillomavirus-16 in oral and oropharyngeal cancer'.

The creation of bony attachments for engineered craniofacial muscle constructs

Rishma Shah
Eastman Dental Institute,
University College London

Patients with a congenital or acquired absence of facial muscle have problems not only with their appearance but also with movement of the face and jaws. The creation of new muscle using the patient's own cells could avoid the limitations of current treatments.

Our previous research has developed human facial muscle in the laboratory. However, for muscles to function properly they must be attached to bone. The proposed research will aim to recreate the muscle tissue in the laboratory but with bony attachments. This new muscle tissue could be used to investigate the response to new treatments and eventually be implanted where tissue is missing.

To investigate changes in dental plaque microbiology following inpatient hospital admission

Ian Needleman
Professor of Restorative Dentistry and Evidence-Based Healthcare,
Eastman Dental Institute,
University College London

Poor oral health is a recognised risk factor for the development of hospital-acquired infections. Some studies have shown that dental plaque of hospitalised patients contains bacteria that cause respiratory infections. This research aims to examine what happens to oral health and dental plaque microbiology following hospital admission.

The role of human papillomavirus-16 in oral and oropharyngeal cancer

Andrew Schache
Clinical Research Fellow and SpR, University of Liverpool and University Hospital Aintree

Head and neck cancer is the sixth most common cancer worldwide, with 500,000 cases diagnosed annually. Oral and oropharyngeal cancers comprise the majority of these cases and both are increasing in incidence. Recent evidence strongly links viruses from the 'wart family' – human papillomavirus (HPV) – to the development of a significant proportion of these cancers.

This research aims to define the best diagnostic test for HPV-positive cancers and, importantly, improve the understanding of the role of viruses in cancer development through the use of novel techniques. This will allow a more personalised approach to the treatment of individuals diagnosed with these cancers.

Future plans

- A joint FDS–Wellcome Trust research fellowship in dental surgery will be offered in 2011.
- The Licence in Dental Surgery will be updated to fit current professional practice.
- We will continue to publish the Faculty Dental Journal for our members.

The Faculty of General Dental Practice (UK)

The FGDP(UK) aims to improve the standard of care delivered to patients through standard setting, postgraduate training and assessment, education and research.

Until recently it has been difficult for general dental practitioners to access formally recognised postgraduate training while maintaining a full-time commitment to practice. The FGDP(UK)'s postgraduate training programmes include diplomas for general dental practitioners in a number of areas, including restorative dentistry and primary care orthodontics.

The primary care orthodontics programme, developed jointly with the British Orthodontic Society, is designed for primary care dentists seeking to enhance their skills in orthodontics further and those wishing to develop a special interest in orthodontics. The training programme, leading to a recognised diploma in orthodontics for primary care dentists, provides a quality standard to assist primary care trusts wishing to contract for special interest services.
The diploma in restorative dentistry provides a very similar approach, again providing a quality standard to assist primary care trusts wishing to contract with dentists for special interest services.

A further addition to the FGDP(UK) course portfolio has been the addition of a certificate in mentoring aimed at all dental care professionals.

The Faculty is now into the second year of a joint project with the British Association of Oral and Maxillofacial Surgeons focusing on national new registration of patients with

avascular necrosis of the jaw, including bisphosphonate-related osteonecrosis (BRONJ), a disease resulting from the temporary or permanent loss of the blood supply to the jaw. An interim report will be produced in early 2011.

The FGDP(UK) continues to collaborate with the FDS in the delivery of the MJDF RCS Eng examination, a first-level postgraduate examination that assesses the curriculum for foundation training in dentistry.

The FGDP(UK)'s lay advisory group continued to highlight patient concerns around the practice of tooth whitening in the UK. Informal research has indicated that tooth whitening services continue to be carried out by non-dental professionals without the supervision of a dentist and using treatments that exceed the approved concentration of 0.1% hydrogen peroxide.

The Faculty continues to expand its activities and relevance to the wider dental team including dental nurses, hygienists, therapists, dental technicians and clinical dental technicians.

Future plans

- With our lay advisory group, we will work to raise awareness of the oral health care needs of older people.
- We will continue to strive for a unified approach to standard setting within dentistry, particularly with regard to revalidation.
- We will publish a revised edition of *Selection Criteria for Dental Radiography*.
- We will deliver a course in minor oral surgery.

Funding Partnerships

As a registered charity (number 212808) the College relies upon charitable support to underpin its work in advancing surgical standards through education, research and training.

We are grateful to our many supporters, whose donations and encouragement are crucial as the demands on the College's limited resources become ever greater. We would like to acknowledge in particular the following charitable trusts, foundations, companies and individuals.

Foundations, charitable trusts, associations and individuals

Andrew Anderson Trust
Ashley Charitable Trust
Ballinger Charitable Trust
Barbara Whatmore Charitable Trust
Bedell Trust
Bernard Sunley Charitable Foundation
Brain Tumour UK
Brinsley Ford Charitable Trust
British Association of Plastic, Reconstructive and Aesthetic Surgeons
CA Redfern Charitable Foundation
Coulthurst Trust
Cowen Charitable Trust
Donald Forrester Trust
Dunhill Medical Trust
East Grinstead Medical Research Trust
Enid Linder Foundation
Ethel and Gwynne Morgan Charitable Trust
ET and MG Hall Charitable Trust
Fitton Trust
Frances and Augustus Newman Foundation
GD Herbert Charitable Trust
George and Esme Pollitzer Charitable Settlement
George Drexler Foundation
Gilbert and Eileen Edgar Foundation
GM Morrison Charitable Trust
Golden Bottle Trust
Golden Charitable Trust
Grand Lodge of Freemasons 250th Anniversary Fund
Henry Lumley Charitable Trust
Hong Kong Freemasons
Hospital Saturday Fund
Huggard Charitable Trust
Idlewild Trust
Joseph Strong Frazer Trust
JKW Trust
Laurence Misener Charitable Trust
Leche Trust
Lord Leverhulme's Charitable Trust
MLA Prism Fund
Mr and Mrs Leon Grant
Needlemaker's Company
Peacock Charitable Trust
Pelican Cancer Foundation
Penrose Trust
Philip King Charitable Settlement
Radcliffe Trust
The Roger Raymond Charitable Trust
Rose Foundation
Rosetrees Trust
Shears Foundation
Simone Prendergast Charitable Trust
Sir Samuel Scott of Yews Trust
Society for Cardiothoracic Surgery in Great Britain and Ireland
Sue Hammerson Charitable Trust
Swann-Morton Foundation
Thriplow Charitable Trust
Tony Metherell Charitable Trust
Vascular Surgical Society of Great Britain and Ireland
WE Dunn Charitable Trust
Wesleyan Charitable Trust
Wolfson Foundation
Worshipful Company of Barbers
Wyndham Charitable Trust

Eagle Project (Phase 3) individual support

Mr D Alderson
Miss S Boddy
Mr S Cannon
Mr C Chilton
Mr R Collins
Mrs L de Cossart
Mr C Getty
Mr R Greatorex
Sir B Jackson
Mr D Jones
Mr A Marston
Mr C Milford
Mr P Moore
Mr M Morgan
Professor Sir P Morris
Mr D Murray
Professor A Narula
Mr D O'Riordan
Mr M Parker

Mr B Rees
Mr B Reeves
Professor J Stanley
Professor I Taylor
Mr W Thomas
Sir I Todd
Mr D Ward
Professor N Williams

Corporate support

Advance Health
Allergan Limited
American Medical Systems UK Ltd
Ansell (UK) Ltd
Anspach
ApaTech Ltd
Archimedes Pharma Ltd
Astellas Pharma Ltd
AstraZeneca UK Ltd
B Braun Medical Ltd
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Biomet UK Ltd
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Boehringer Ingelheim UK
Boston Scientific Ltd
Calumet Photographic
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Carl Zeiss Ltd
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Codman Ltd
Coloplast Limited
Covidien (UK) Commercial Ltd
Danone Baby Nutrition
DePuy Spine
DePuy UK
Downs Surgical
Edwards Lifesciences Ltd
Eschmann Holdings Ltd
Ethicon Endo-Surgery UK
Ethicon UK
Ethicon Women's Health and Urology
Forth Medical Ltd
Globus Medical UK Ltd
ICAP plc
Integra NeuroSciences Ltd
Karl Storz Endoscopy (UK)
KCI Medical (UK) Ltd
Maquet Ltd
Medacta UK Ltd
Medartis Ltd
Medical Protection Society
Medtronic Limited
Mentor Medical Systems Ltd
Miad UK Ltd
Mölnlycke Health Care Ltd
Novartis Pharmaceuticals UK Ltd
NuVasive UK Ltd
Nycomed UK Ltd
Olympus Medical
Ortho Solutions Ltd
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Smith and Nephew Orthopaedics Ltd
SpineVision Ltd
St Jude Medical UK Ltd
Stryker UK
Surgi C Ltd
Synthes Ltd
Thomas Tunnock Ltd
Vascutek Ltd
Wesleyan Medical Sickness
WL Gore and Associates UK Ltd

Endowed and restricted funds

Blond McIndoe Fund
Buckstone Browne Gift
Colledge Family Memorial Fellowship Fund
Doctor Shapurji H Modi Memorial ENT Fund
Edward Lumley Fund
Estate of the late Dr MP Starritt
Fellows Fellowship Fund
Guyatt Fund – Sir Alan Parks Research Fellowship
Harold Bridges Bequest
Harry Morton Fund
Laming Evans Research Fund
Lea Thomas Fund
Lillian May Coleman Fund
Margaret Witt Scholarship Fund
Norman Capener Fund
Osman Hill Collection and Research
Parks Visitorship
Peter and Nora Locan Fund
Philip and Lydia Cutner Fund
Preiskel Family Fund
Shortland Legacy
Simpson Legacy
Vandervell Research Fund

Legacies

The late Mrs MD Andrews for general charitable purposes
The late Mr MM Brown for surgical research
The late Mrs J Butt for surgical research
The late Miss DK Cooke for general charitable purposes
The late Miss PC Curry for surgical research
The late Mrs NO Curtis for general charitable purposes
The late Mrs EM Deakin for general charitable purposes
The late Mr JR Dickson for general charitable purposes
The late Miss GE Evans for general charitable purposes
The late Dr J Hand for general charitable purposes
The late Mrs MJP Haydon for general charitable purposes
The late Mrs DMS Loudan for general charitable purposes
The late Miss BM Mackenzie for general charitable purposes
The late Mr RF McNab-Jones for general charitable purposes
The late Dr H Morton for general charitable purposes
The late Mr AR Mowlem for general charitable purposes
The late Miss J Panter for general charitable purposes
The late Mrs MG Pearce for research in heart surgery
The late Mrs E Rashleigh for research into heart disease
The late Mrs G Shrimpton for surgical research
The late Mr DP Winks for surgical research
The late Mr RE Wood for general charitable purposes

For more information about supporting the College's charitable activities in education, research and training please contact the Development Office
t: 020 7869 6086
e: development@rcseng.ac.uk

You can also visit www.rcseng.ac.uk/fundraising.

Trustees' Report for the year ended 24 June 2010

Reference and administrative details

Charter
The Royal College of Surgeons of England was established by royal charter in 1800 to promote and encourage the study and practice of the art and science of surgery. Its earlier history lies in the records of the City Companies of Surgeons and Barber Surgeons. The affairs of the College are regulated by its founding and subsequent charters and ordinances. The most recent of these was granted in March 1992. The College is a registered charity and its number is 212808.

Constituent parts
For administrative purposes, the College comprises the Commonalty of Surgeons, the Faculty of Dental Surgery and the Faculty of General Dental Practice (UK).

Council
The Council is the governing body of the College and the elected members of Council are its trustees. Council consists of 24 elected surgical fellows and two dental surgery fellows elected by the Board of the Faculty of Dental Surgery. In addition, a number of invited members representing specific interests, including the Dean of the Faculty of General Dental Practice (UK), attend Council meetings. The elected members of Council throughout the year to 24 June 2010 were:

President: **Mr J Black**

Vice-Presidents: **Mr W Thomas**
Mr R Collins

Professor A Mundy	**Mr I McDermott**	**Miss S Boddy**
Professor D Neal	**Professor N Williams**	**Professor D Willmot**
Mr D O'Riordan	**Professor J Stanley**	**Mr S Cannon**
Mr D Jones	**Professor M Horrocks**	**Professor D Alderson**
Professor I Taylor	**Mr D Ward**	**Mr C Milford**
Mr B Rees	**Mr R Greatorex**	**Professor J Shepherd**
Mr C Chilton	**Mr J Getty**	**Miss C Marx**
Professor A Narula	**Mr M Parker**	

In July 2010 Mr J Black was re-elected President and Mr R Collins was re-elected as Vice-President. Professor J Stanley was elected second Vice-President. Professor G McGrouther, Mr M Bircher, Mr I Eardly, Mr P Lamont, and Professor C Lavy were admitted to the Council. Professor A Mundy, Mr D Jones, Mr B Rees, Mr C Chilton, and Mr I McDermott were demitted.

The principal officers employed by the College were

Chief Executive	**Mr A Bennett**
Advisor to the President	**Mr C Duncan**
Communications	**Dr A Cook**
Professional Standards and Regulation	**Mrs K Smith**
Education	**Prof M Larvin**
Examinations	**Mr A Woodthorpe**
Research	**Mr M Coomer**
Internal Services	**Mrs J Weller**
Finance	**Ms A da Silva**
Development	**Mr J Fountain**
Registrar of the Faculty of Dental Surgery	**Mr J Vandridge Ames**
Registrar of the Faculty of General Dental Practice (UK)	**Mr I Pocock**

Professional advisors
Bankers

C Hoare & Co	37 Fleet Street, London EC4P 4DQ
HSBC Bank PLC	60 Queen Victoria Street, London EC4N 4TR

Auditors

Crowe Clark Whitehill LLP	St Bride's House, 10 Salisbury Square, London EC4Y 8EH

Solicitors

Bircham Dyson Bell	50 Broadway, London SW1H 0BL
Eversheds	One Wood Street, London EC2V 7WS

Investment managers

Newton Investment Management Ltd	160 Queen Victoria Street, London EC4V 4LA

Structure, governance and management

Council is responsible for the overall direction of the College and delegates the direction of specific functions to individual members of Council. Trustees, when elected by postal ballot by fellows and members of the College, are given an induction course on the College and ongoing training on their responsibilities and other matters as required. The College management is organised into directorates based on the College's activities. The chief executive is responsible for the overall management of the College and delegates management of specific functions to directors, each of whom is responsible for supporting the departments in their directorates under the guidance of the responsible member of Council. Directorates, their functions and roles, and Council members involved during the year, were as follows:

DIRECTORATE		COUNCIL MEMBER RESPONSIBLE
Finance	Overall divisional responsibility	Professor A Narula
	Accounting and financial control	Professor A Narula
	Investment management	Mr J Getty
Internal Services	Overall divisional responsibility	Mr J Getty
	Accommodation, facilities, staff policies and procedures and health and safety	Mr J Getty
	Information systems	Professor D Wilmot
	Library and Information Services	Mr D Jones
	Museums and Special Collections	Mr D Jones
Professional Affairs	Overall divisional responsibility	Mr R Collins
	Professional standards	Mr R Greatorex
	Regional policy – training	Professor J Stanley
	Regional policy – professional support	Professor D Alderson and Professor I Taylor
	Education	Professor M Horrocks
	Quality assurance and inspection	Mr C Milford
	Research	Professor N Williams
	Examinations and assessment	Mr M Parker
Communications, Dental	Overall divisional responsibility	Mr W Thomas
Faculties and Presidential	PR and communications	Mr W Thomas
	Policy	Professor A Mundy
	Publications	Mr W Thomas
	Patient Liaison Group	Mr R Greatorex
	Faculty of Dental Surgery	Professor D Willmot
	Faculty of General Dental Practice (UK)	Mr R Ladwa

The Faculty of Dental Surgery and the Faculty of General Dental Practice (UK) report to Council and have their own committee structure. Each Faculty has a Dean's committee concerned with day-to-day management. The Faculty of General Dental Practice (UK) has 21 regional divisions that manage their own affairs under the direction of the Faculty; their results are included in these financial statements.

Council and the boards of the two dental faculties are elected by the subscribing fellows and members. The numbers for each category are as follows:

		2009–10	2008–09	2007–08	2006–07
SURGEONS	UK	8,108	8,048	8,376	7,969
	Overseas	1,940	1,829	1,799	1,477
FACULTY OF DENTAL SURGERY	UK	2,844	2,547	2,604	2,472
	Overseas	394	404	478	415
		13,286	12,828	13,257	12,333
FACULTY OF GENERAL DENTAL PRACTICE (UK)		4,525	4,780	3,890	3,392

Objectives and aims
The Royal College of Surgeons of England was established for the study and promotion of the art and science of surgery.

Mission statement
The Royal College of Surgeons of England is committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care.

Core values
We will:
- put the interests of patients at the heart of all we do;
- provide leadership and support for surgeons of all specialties;
- develop the potential of surgeons through education, training and research;
- work closely with the specialist associations and other organisations to achieve our mutual aims;
- foster and develop the College's employees;
- promote equality of opportunity and act against discrimination in all aspects of College life; and
- be fair, responsible, open and accountable for all we do.

A summary of the College's strategic aims

1. Provide strong leadership and support for surgeons in all matters relating to their surgical practice, throughout their surgical careers.
2. Work with patients, the general public and government to improve surgical services.
3. Consolidate the College's position as a leading national and international centre for surgical education, training, assessment, examination and research.
4. Lead the whole multi-professional surgical team in all matters relating to the care of the surgical patient, including the surgical treatment of children, and further develop the College's role in setting and maintaining standards of practice for all the members of that team throughout their careers.
5. Develop the College's structure and function to allow it to achieve its goals.
6. Promote, by consultation and collaboration with other surgical royal colleges, the specialist associations and other interested parties, the development of an effective single voice for surgery on relevant professional issues.

Public benefit

The Royal College of Surgeons of England delivers public benefit through its wide range of activities that influence and support the professional development of surgeons and the delivery of surgical services, for the benefit of patients, surgeons and trainee surgeons. We are committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care. We have approximately 18,000 members and we provide strong leadership and support for surgeons in all matters relating to their surgical practice, throughout their surgical careers.

The trustees confirm that they have had due regard to the guidance issued by the Charity Commission on public benefit and further confirm that the activities of the College are carried out for public benefit. Our work is based on a number of the charitable purposes defined under the Charities Act 2006, chiefly the advancement of education, the advancement of health or the saving of lives, and the advancement of the arts, culture, heritage or science. We engage directly with the public through the Hunterian Museum, broadcast media and our publications and journals, such as the *Annals* and *Bulletin*. In addition to this direct engagement, the College also delivers public benefit indirectly through the training and support given to surgeons, enabling them to provide high quality care to patients. The next section outlines key activities in 2009–2010.

Activities and achievements

The College's role is to maintain the highest standards of surgical practice and patient care. The College carries out many diverse activities to achieve this, some of which are discussed below. More detailed information can be found in our Annual Report.

The College was given the responsibility of setting standards for surgeons as part of the forthcoming system of revalidation for doctors to be introduced by the General Medical Council (GMC) in 2011. We worked with the surgical specialty associations to develop surgery-specific standards, based on a common template for all doctors, covering areas such as leading the theatre team; using the World Health Organization's *Surgical Safety Checklist* and taking part in national audits such as the central cardiac audit database. The standards were approved by the GMC in January 2010 and we released guidance to support surgeons involved in piloting revalidation in June 2010. The College has also developed an online portfolio to help surgeons collect the information they need to present for revalidation. Surgeons can upload documents that demonstrate how they have met the standards and also make notes on what they have learnt from different meetings and events. A trial online portfolio was launched in November 2009 and surgeons are providing their feedback.

The College has supported over 140 hospitals in maintaining and improving surgical standards and patient care through the Invited Review Mechanism (IRM). The IRM is designed to support local review procedures by providing independent advice and expertise to help trusts determine if there is a cause for concern about the performance of a surgeon or surgical unit and make recommendations for improvement where necessary. Through the IRM we also provide independent guidance to support trusts in deciding how to structure their services for the future.

The College is the leading provider of postgraduate surgical education in the UK. It has developed one of the most advanced specialised teaching facilities in the world. Our facilities are an important national resource from which to pilot, quality-assure and deliver innovation in education. The Wolfson Surgical Skills Centre is the largest cadaveric dissection workshop in the UK, enabling surgeons to develop their practical knowledge of surgical anatomy and undertake skills-based training. The Education Centre offers a range of courses for surgeons and the wider surgical team from foundation to consultant level and across the surgical specialties. Courses are developed by appointed surgical tutors in conjunction with specialty associations and support the curricula for surgical trainees and consultants' continuing professional development. Additionally, courses are offered on a regional basis. In 2009–2010 we held 597 courses with 8,735 participants in the College and ran 181 courses with 464 participants overseas.

Over the past year, the Joint Committee on Surgical Training (JCST) developed a 'good practice toolkit' providing tools, models and techniques to assist those responsible for the selection of surgical trainees. It also conducted a survey of all surgical trainees at the end of their surgical placements. This asked trainees to evaluate and comment on the quality of their placements against JCST training standards and their engagement with the curriculum. The findings were reported to, and acted on, by the schools of surgery – the bodies responsible for training placements. The findings were also considered by the specialist advisory committees, who oversee the quality of training in individual surgical specialties.

Future plans
In 2010–11 the College will continue to support trusts to deal with performance issues through the IRM and also continue to collaborate with the National Patient Safety Agency and Care Quality Commission on the development of the surgical service. The Education Department will continue to develop courses to support new procedures and technology and also courses to support patient safety.

Financial review
For a full understanding of the financial activities of the College it is necessary to review the Consolidated Statement of Financial Activities and Consolidated Balance Sheet (pages 36 and 37).

The aggregate deficit of £0.8 million shown on the Consolidated Statement of Financial Activities, before investment losses, consists of a neutral result on unrestricted funds, a deficit of £0.7 million on restricted funds and a deficit of £0.1 million on endowed funds.

The neutral result on unrestricted funds was due to a combination of factors. There was an increase in examinations and subscriptions income while the cost of running the organisation remained static due to cost-saving initiatives. The additional income enabled all the College's expenditure to be funded and achieve the neutral result.

The deficit on restricted funds of £0.7 million (before transfers) comprises a net decrease in grants held of £1.2 million and an increase of £0.5 million in trust fund balances used for funding educational, research and museum project developments. The decrease in grants comprises a net decrease in other grants of £1.8 million due to research, educational and other project funding received in previous years being utilised during the current financial year coupled with a net Eagle Project refurbishment programme increase of £0.6 million. The increase of £0.5 million in trust fund balances is due to additional research funds being received.

Endowed funds decreased by £0.1 million (before transfers) consisting of investment portfolio management fees charged against the capital value of the fund.

When the aggregate deficit of £0.8 million in the Consolidated Statement of Financial Activities is amalgamated with the increase of £7.9 million in the capital value of the College's investment portfolio, an overall increase in net worth of £7.1 million is the outcome for the year. The capital value of the College's investment portfolio has benefited from favourable economic conditions at the close of the financial year.

Income
Overall income of £27.0 million (2009: £27.2 million) was 1% or £0.2 million lower than the previous year. Under the Charities Statement of Recommended Practice (SORP) 2005, income is required to be reported under three categories: *Incoming resources from generated funds* of £9.8 million (2009: £11.4million), *Incoming resources from charitable activities* of £17.2 million (2009: £15.4 million), and *Other incoming resources* of £0.0 million (2009: £0.4million).

- The value of donations and gifts received was significantly lower than in the previous year, mostly in restricted funds. This is mainly due to donations received for education and research projects being lower than in the previous year.
- Legacies are unpredictable and were considerably higher than in the previous year.
- Grant income decreased due to reduced project funding being received as the College no longer runs the National Collaborative Centre for Acute Care.
- Residential and conference income decreased only slightly due to fewer conferences being held.
- Investment income levels were lower than in the previous year for unrestricted and restricted funds due to the impact of the adverse economic climate on dividends.
- Course income has increased marginally due to a higher number of courses being organised in the Education Department and dental faculties and also due to an increase in the trainee fee for using the Intercollegiate Surgical Curriculum Programme.
- Examination income grew substantially due to increases in surgical and dental faculties' income as a result of a higher number of candidates than in the previous year.
- Subscription income shows an increase due to a rise in the level of subscription in all areas and an increased number of surgical and Faculty of Dental Surgery subscribers, despite a decrease in the number of Faculty of General Dental Practice (UK) subscribers.
- Rents, charges and sales income was in line with the previous year.
- Other income relates to the surplus on sale of a property in the previous financial year.

Expenditure
Expenditure of £27.8 million (2009: £26.8million) was incurred during the year on all activities and reflected a 3.7% or £1.0 million increase on the previous year. Under SORP 2005, expenditure is required to be reported under three categories: *Cost of generating funds* of £2.9 million (2009: £3.1 million), *Charitable expenditure* of £24.2 million (2009: £23.0million), and *Governance* costs of £0.7 million (2009: £0.7 million).

The *Cost of generating funds* category has decreased due to savings in residential and conference costs.

Charitable expenditure includes the majority of categories:
- The level of education and course expenditure was higher than in the previous year due to one-off rationalisation costs following a review as well as increased overhead and depreciation costs following the completion of the new Eagle Project facilities.
- Expenditure on standards, regulation and examinations has increased due to the higher costs of running the dental faculties' examinations.
- The level of research expenditure has increased significantly due to new post-CCT (Certificate of Completion of Training) transplant fellowships being awarded.
- Clinical Effectiveness Unit and other funded-project expenditure has decreased due to the College no longer running the National Collaborative Centre for Acute Care.
- Expenditure on museum and library services has remained static.
- Expenditure on communications and publishing has increased due to the College tri-annual overseas trip and also a new marketing initiative.
- Other professional activities have decreased due to cost savings across all areas of activity.

Governance costs decreased due to staff savings.

Total capital expenditure for the year was £2.3 million of which £0.4 million has been spent in selectively improving general facilities while capital expenditure of £1.5 million has been incurred on the Eagle Project and £0.4 million on other information systems projects.

The College's grant-making policy is that surgical research fellowships awarded by the College are only eligible to surgical trainees who are members of the College (hold the MRCS) and who have entered their period of specialty training (specialist registrars). The overriding objective of the surgical research project must be to improve care of surgical patients and the projects should be based on the principles of translational research, ie research examining a specific clinical problem.

Subsidiary company
Hunter Trading Limited is a wholly owned subsidiary of the College that markets conference and residential facilities not required for the College's own use. A surplus of £0.1 million was achieved in 2010 (2009: £0.2 million) as conference income decreased while costs remained static. Its activities are consolidated in these financial statements (see note 10).

Investment policy and performance
The upturn of world markets has resulted in gains of £3.8 million in unrestricted funds with the portfolio being valued at £24.3 million at year end. The restricted and endowed funds portfolios were valued at £30.1 million at year end and have benefited from gains of £4.2 million in the year.

The general funds investment objective is to maximise total returns after generating income of £840k. The Common Investment Fund and other funds investment strategy is to provide income of £1.12 million and thereafter provide a balance between capital growth and income. The College does not invest directly in tobacco stocks. The investment objectives were met for the general, common investment and other funds. The investment performance was satisfactory in the current economic conditions.

The investment powers of the College detailed in the ordinances attached to the 1992 charter have now been widened by the Trustee Act 2000.

Reserves policy
The College's expenditure is more predictable while its income is of a more variable and uncertain nature. The College therefore considers it necessary to hold reserves. The College holds reserves in the form of capital designated funds to provide a continuous flow of income to help support the cost of charitable activities. The balance of this fund approximates 9–12 months of unrestricted operational expenditure. The College's reserves policy is that the capital designated fund should not fall below nine months of unrestricted operational expenditure. The balance of the College's designated funds is represented by tangible fixed assets that are not readily converted into cash. Additional working reserves are held for operational purposes. The College considers that its reserves are at an acceptable level in the short-term and the trustees will continue to monitor its reserves stringently.

Resources
The overall increase in resources during the year was approximately £7.1 million which, when amalgamated with existing funds, results in a net worth of £70.0 million. Of this, £26.6 million represents endowed funds' assets, where only the income, not the capital, can be spent on purposes specified by the donors, while a further £13.9 million is restricted in how it can be used as it consists of project grants and trust balances.

The unrestricted funds of £29.5 million include designated funds of £7.7 million equating to the unrestricted fixed assets used by the College in its activities, a capital designated fund of £17.0 million, which is invested to produce income to support the College's charitable activities and working reserves for the College and its two dental faculties of £4.8 million.

The Balance Sheet (page 37) outlines the main asset and liability categories aggregating to the net worth of the College, while the Cashflow Statement (page 38) tabulates the impact of operating and investment activities on cash and bank resources.

Overall this has been a good year for the financial position of the College due to its investment gains. However, the College continues to face a number of uncertainties and therefore continued professional and prudent management of resources is essential if the College is to maintain financial equilibrium and so be in a position to react positively to future challenges.

Risk management
Council acknowledge their responsibility for ensuring adequate levels of risk management and internal control. This is supported by the strategic plan and a four-year business plan for the College. A risk register is in place and is regularly reviewed. The main risks identified are investment performance and generating sufficient levels of income; these risks have been ameliorated by diversified portfolios and continuous review. Internal financial controls fulfil the Charity Commission guidelines in all material respects and are enhanced by strong budgetary and management accounting procedures.

Custodian trustee
The College acts as custodian trustee for the Sir Ratanji Dalal Research Scholarship Fund (research scholarship in tropical surgery or medicine) and The Colledge Family Memorial Fellowship (which awards travelling fellowships to surgeons). Their financial statements are audited by Crowe Clark Whitehill LLP. Both these funds hold investments in their own name and have their own bank accounts, entirely segregated from those of the College.

At 22 September 2010, the value of the Sir Ratanji Dalal Research Scholarship Fund endowed fund was £0.6 million (2009: £0.6million) and its unrestricted fund was £0.09 million (2009: £0.06 million). The trustees of this fund are the President of The Royal College of Surgeons of England and the President of The Royal College of Physicians, who are jointly responsible for the safeguarding of its assets. Annual financial statements are prepared and presented to the trustees of this fund.

At 24 June 2010, the value of The Colledge Family Memorial Fellowship endowed fund was £2.2 million (2009: £1.5 million) and its unrestricted fund was £0.06 million (2009: £0.02 million). The trustees of this fund are Ms S Shapiro, Professor A Narula and The Royal College of Surgeons of England, who are jointly responsible for the safeguarding of its assets. Annual financial statements are prepared and presented to the trustees of this fund.

Statement of Trustees' Responsibilities

The trustees are responsible for preparing the Trustees' Report and the financial statements in accordance with applicable law and regulations.

Charity law requires the trustees to prepare financial statements for each financial year in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards) and applicable law.

Under charity law the trustees must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the charity and the group and of their net incoming resources for that period. In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently;
- make judgments and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity and the group will continue to operate.

The trustees are responsible for keeping proper accounting records that are sufficient to show and explain the charity's transactions and disclose with reasonable accuracy at any time the financial position of the charity and the group and enable them to ensure that the financial statements comply with the Charities Act 1993. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Signed on behalf of the elected members of Council

Mr J Black President

Professor A Narula Treasurer

1 December 2010

Independent auditor's report

To the trustees of The Royal College of Surgeons of England

We have audited the group and parent charity financial statements of The Royal College of Surgeons of England for the year ended 24 June 2010 which comprises the Consolidated Statement of Financial Activities, the Consolidated Balance Sheet, the Consolidated Cash Flow Statement and the related notes 1 to 15. These financial statements have been prepared under the accounting policies set out therein.

This report is made solely to the charity's trustees, as a body, in accordance with section 44 of the Charities Act 1993. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditors' 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 charity and the charity's trustees as a body for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of trustees and auditors

The trustees' responsibilities for preparing the Trustees' Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice) are set out in the Statement of Trustees' Responsibilities.

We have been appointed as auditors under section 43 of the Charities Act 1993 and report in accordance with regulations made under section 44 of that Act. Our responsibility is to audit the financial statements 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 Charities Act 1993. We also report to you if, in our opinion, the Trustees' Report is not consistent with the financial statements, if the charity has not kept proper accounting records or if we have not received all the information and explanations we require for our audit.

We read other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. The other information comprises only the Foreword from the President, Introduction from the Chief Executive, About the College, Promoting High Standards of Patient Care, Leading the Profession, Supporting Surgeons through Education and Training, Surgical Research and New Techniques, The National College, The College Museums, The Dental Faculties, Funding Partnerships and the Trustees' Report. 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 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 and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgments made by the trustees in the preparation of the financial statements, and of whether the accounting policies are appropriate to the group's and charity'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 are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion:

- the financial statements give a true and fair view, in accordance with United Kingdom Generally Accepted Accounting Practice of the state of the group and the parent charity's affairs as at 24 June 2010 and of the group's incoming resources and application of resources in the year then ended; and
- the financial statements have been properly prepared in accordance with the Charities Act 1993.

Crowe Clark Whitehill LLP
Chartered Accountants and Statutory Auditor
London

1 December 2010

Consolidated Statement of Financial Activities for the year ended 24 June 2010

	NOTES	UNRESTRICTED FUNDS £000s	RESTRICTED FUNDS £000s	ENDOWED FUNDS £000s	TOTALS 2010 £000s	TOTALS 2009 £000s
Incoming resources						
Incoming resources from generated funds:						
Voluntary income:						
Donations and gifts		77	1,819	-	1,896	2,968
Legacies		878	519	-	1,397	835
Grants		-	1,607	-	1,607	2,320
Activities for generating funds:						
Residential, conference and other		2,744	-	-	2,744	2,837
Investment income		1,020	1,155	-	2,175	2,435
Incoming resources from charitable activities:						
Courses		5,566	497	-	6,063	5,879
Examinations		4,271	-	-	4,271	3,186
Subscriptions		4,421	-	-	4,421	4,027
Rents, charges, sales		997	1,425	-	2,422	2,346
Other incoming resources:						
Surplus on sale of property		-	-	-	-	354
Total incoming resources		**19,974**	**7,022**	**-**	**26,996**	**27,187**
Resources expended	2					
Cost of generating funds:						
Fundraising costs for raising voluntary income		319	-	-	319	325
Investment management fees		51	92	100	243	216
Residential, conference and other trading costs		2,376	-	-	2,376	2,572
		2,746	**92**	**100**	**2,938**	**3,113**
Charitable expenditure:						
Education and courses		6,150	1,270	-	7,420	7,004
Standards, regulation and examinations		5,695	1,631	-	7,326	6,726
Research grants	3	5	2,825	-	2,830	1,837
Clinical Effectiveness Unit and other projects		29	973	-	1,002	1,518
Museums and library		1,399	663	-	2,062	2,133
Communications and publications		1,621	202	-	1,823	1,662
Other professional activities		1,682	80	-	1,762	2,127
		16,581	**7,644**	**-**	**24,225**	**23,007**
Governance		647	-	-	647	693
Total resources expended		**19,974**	**7,736**	**100**	**27,810**	**26,813**
Changes in resources before transfers		-	(714)	(100)	(814)	374
Transfer between endowed and restricted funds	11	-	301	(301)	-	-
Changes in resources before other recognised gains and losses		**-**	**(413)**	**(401)**	**(814)**	**374**
Net gain / (loss) on investments	10	3,790	184	3,983	7,957	(11,886)
Surplus on sale of investment property		-	-	-	-	69
Net movement in resources in the year		**3,790**	**(229)**	**3,582**	**7,143**	**(11,443)**
Brought forward 25 June 2009		25,694	14,162	23,003	62,859	74,302
Balance carried forward 24 June 2010		**29,484**	**13,933**	**26,585**	**70,002**	**62,859**

All activities are continuing activities. The notes to the financial statements are on pages 39 to 48.

Consolidated Balance Sheet as at 24 June 2010

	NOTES	UNRESTRICTED FUNDS £000s	RESTRICTED FUNDS £000s	ENDOWED FUNDS £000s	TOTALS 2010 £000s	TOTALS 2009 £000s
Fixed assets						
Tangible fixed assets	5	7,632	7,335	-	14,967	14,341
Investments	10	24,262	3,791	26,303	54,356	47,008
		31,894	**11,126**	**26,303**	**69,323**	**61,349**
Current assets						
Stock		132	-	-	132	154
Debtors	6	2,781	264	-	3,045	3,675
Cash and short-term deposits	7	3,517	2,543	282	6,342	6,323
		6,430	**2,807**	**282**	**9,519**	**10,152**
Current liabilities						
Creditors: amounts falling due within one year	8	(8,725)	-	-	(8,725)	(8,452)
Net current (liabilities) / assets		**(2,295)**	**2,807**	**282**	**794**	**1,700**
Long-term Liabilities						
Creditors: amounts falling due after more than one year	8	(115)	-	-	(115)	(190)
Net assets		**29,484**	**13,933**	**26,585**	**70,002**	**62,859**
Funds						
Permanent endowment and other restricted funds	11	-	13,933	26,585	40,518	37,165
Unrestricted funds:	12					
Designated funds		24,632	-	-	24,632	21,484
Working reserves		4,852	-	-	4,852	4,210
		29,484	**13,933**	**26,585**	**70,002**	**62,859**

The notes on pages 39 to 48 form part of these financial statements.

The parent charity only Balance Sheet is identical to the Consolidated Balance Sheet presented above except that debtors and creditors amounts falling due within one year, and subtotals for current assets and current liabilities are higher by £75,000 (2009: £205,000).

Approved on behalf of the elected members of Council and authorised for issue on 1 December 2010.

Mr J Black President

Professor A Narula Treasurer

Consolidated Cashflow Statement for the year ended 24 June 2010

	NOTES	UNRESTRICTED FUNDS £000s	RESTRICTED FUNDS £000s	ENDOWED FUNDS £000s	TOTALS 2010 £000s	TOTALS 2009 £000s
Net cash inflow / (outflow) from operating activities	**a**	1,714	155	(100)	1,769	1,441
Net cash (outflow) / inflow from capital expenditure and financial investment	**b**	(1,571)	(280)	101	(1,750)	(1,483)
		143	(125)	1	19	(42)
Management of liquid resources	**c**	(356)	14	-	(342)	(40)
(Decrease) / increase in cash in year	**d**	**(213)**	**(111)**	**1**	**(323)**	**(82)**
a) Reconciliation of changes in resources to net inflow from operating activities						
Net (outgoing) / incoming resources before revaluations		-	(714)	(100)	(814)	374
Depreciation		863	870	-	1,733	1,455
(Profit) on disposal of fixed assets		-	-	-	-	(352)
Decrease / (increase) in stocks		22	-	-	22	(44)
Decrease / (increase) in debtors		631	(1)	-	630	(211)
Increase in creditors		198	-	-	198	219
Net cash inflow / (outflow) from operating activities		**1,714**	**155**	**(100)**	**1,769**	**1,441**
b) Capital expenditure and financial investment						
Payments to acquire tangible fixed assets		(1,012)	(1,347)	-	(2,359)	(2,455)
Receipts from sales of fixed assets		-	-	-	-	378
Purchase of investments		(7,785)	(920)	(8,886)	(17,591)	(15,918)
Receipts from sales of current investments		-	-	-	-	1,768
Receipts from sales of fixed asset investments		8,385	527	9,288	18,200	14,744
Transfer between funds		-	301	(301)	-	-
Change in amounts due between funds		(1,159)	1,159	-	-	-
Net cash (outflow) / inflow from capital expenditure and financial investment		**(1,571)**	**(280)**	**101**	**(1,750)**	**(1,483)**
c) Management of liquid resources						
Increase / (decrease) in short term deposits		**356**	**(14)**	**-**	**342**	**40**
d) Reconciliation of net cash flow to movements in net funds						
(Decrease) / increase in cash in year		(213)	(111)	1	(323)	(82)
Increase / (decrease) in short term deposits		356	(14)	-	342	40
Movement in net funds in year		143	(125)	1	19	(42)
Net funds at 24 June 2009		3,374	2,668	281	6,323	6,365
Net funds at 24 June 2010		**3,517**	**2,543**	**282**	**6,342**	**6,323**

1 Accounting policies

(a) The financial statements have been prepared under the historical cost convention with the exception of investments which are included at market value. The financial statements have been prepared in accordance with the Charities Act, applicable Accounting Standards and the principles of the Statement of Recommended Practice for Accounting and Reporting by Charities 2005 (SORP 2005). All activities derive from the continuing business of the College.

(b) Incoming resources are included in the financial statements as follows: donations, gifts and legacies when they are capable of measurement and become receivable, grants as they become receivable, courses, tuition and examination fees in the period to which they relate, less provisions for doubtful debts, subscriptions on an accruals basis, and investment income as it becomes receivable and is stated together with any relevant tax credit.

(c) Grants payable are charged to the financial statements, in full, in the period that they are notified to the recipients.

(d) Voluntary services donated by Council members and other fellows are not accounted for, as it would not be possible to place a value on them.

(e) Resources expended comprise expenditure, including staff costs, directly attributable to the activity. Where costs cannot be directly attributed they have been allocated to activities on a basis consistent with the use of the resources. Overheads relating to the building and all its services are charged to departments and faculties based upon the area occupied. Those relating to finance, information technology and personnel costs are charged to departments on the basis of their financial activity, level of computer support and numbers of employees, respectively. These are detailed in note 2. All overheads in relation to grant-funded projects are charged, where appropriate, on the basis of their activity.

(f) Fundraising costs comprise the costs incurred in encouraging others to make voluntary contributions to the College and its various activities.

(g) Tangible fixed assets are capitalised where the amount expended is equal to or greater than £1,000 and the College obtains long-term benefit from the expenditure. Heritage assets, which include museum collections, have not been capitalised as the cost of valuation would be disproportionate to the benefit of the resultant information. These mainly comprise the numerous specimens and artefacts collected by John Hunter in the 1700s and presented to the College in 1799, plus historic books related to surgery and medicine. Freehold land and buildings are shown in the Balance Sheet at historic cost. Capital projects which are not complete at the year end are shown as *Construction in Progress*.

(h) Depreciation is charged from the date assets are acquired so as to write them off over their expected useful lives at the following annual rates:

Freehold land	nil	Furniture, fittings and vehicles	25%
Freehold buildings	nil	Computer equipment	25%
Plant and refurbishment	10%		

Freehold buildings are not depreciated as the College has a policy of maintaining them in such a condition that their value, taken as a whole, is not impaired by the passage of time. The Council is of the opinion that any provision would not be material for depreciation and that the buildings are worth at least their book value. No depreciation is charged on *Construction in Progress* expenditure.

(i) Investments are included at market value. Additions are recorded at cost. Disposals during the year are recorded at opening market value, or cost if purchased during the year. Gains or losses on disposal, as well as the change in investment values during the year on continued holdings are shown in the Consolidated Statement of Financial Activities. The activities of the Common Investment Fund, a subsidiary charity of the College, and which acts as an investment pool for most of the College's trust funds' assets, are incorporated in these financial statements.

(j) Stock mainly represents manuals purchased or printed for future courses. It is stated at the lower of cost and realisable value.

(k) Retirement pensions and related benefits are charged to the Consolidated Statement of Financial Activities as contributions fall due. Further details are given in note 13.

(l) Unrestricted funds are available for use at the discretion of the College Council in furtherance of the general charitable objectives of the College.

(m) Designated funds arise from the policy of earmarking those of its unrestricted funds which are not available for general activities. Those represented by fixed assets cannot be utilised unless the assets were to be realised. The reserves placed in the designated capital are required to produce income in future years to fund the core activities of the College.

(n) Endowed and restricted funds are gifts or other grants which can only be applied for a purpose specified by the donor or grantor. All the endowed funds are permanent endowments where the donor has specified that the capital of the gift cannot be expended and that only the income arising from the capital may be used for the purpose named by the donor. None of these funds are available to meet the general costs of the College. Investment management charges are charged to the capital of the endowed funds.

(o) Custodian trustee funds are managed by the College on behalf of other charities and are not included in the financial statements.

(p) The College is a registered charity and as such is exempt from taxation on its income and gains to the extent that they are applied to its charitable purposes.

(q) Hunter Trading Ltd consolidated accounts include the activities, assets and liabilities of the College's wholly owned subsidiary, Hunter Trading Ltd. Were a balance sheet to be prepared excluding Hunter Trading Ltd., the College's debtors and creditors would increase by £75,000 (2009: £205,000).

2 Resources expended

		DIRECT COSTS £000s	GRANTS MADE £000s	ALLOCATED SUPPORT COSTS £000s	TOTAL 2010 £000s	TOTAL 2009 £000s
Cost of generating funds						
Fundraising costs		278	-	41	319	325
Investment management fees		243	-	-	243	216
Residential, conference & other trading costs		1,328	-	1,048	2,376	2,572
		1,849	**-**	**1,089**	**2,938**	**3,113**
Charitable expenditure						
Education and courses		6,605	-	815	7,420	7,004
Standards, regulation and examinations		6,567	-	759	7,326	6,726
Research grants		176	2,551	103	2,830	1,837
Clinical Effectiveness Unit and other projects		869	-	133	1,002	1,518
Museums and library		1,412	-	650	2,062	2,133
Communications and publications		1,651	-	172	1,823	1,662
Other professional activities		1,193	-	569	1,762	2,127
		18,473	**2,551**	**3,201**	**24,225**	**23,007**
Governance		**570**	**-**	**77**	**647**	**693**
Total		**20,892**	**2,551**	**4,367**	**27,810**	**26,813**
Support costs and basis of allocation						
Premises and utilities	Floor area occupied			2,341		2,527
Human resources	Number of staff employed			347		305
Finance services	Budgeted expenditure			509		575
IT and systems support	Equipment and support provided			1,170		876
				4,367		**4,283**

3 Research grants

Purpose of grant	2010 NUMBER AWARDED	2010 TOTAL AMOUNT £000s	2009 NUMBER AWARDED	2009 TOTAL AMOUNT £000s
Research fellowships:				
Liabilities at start of year		(798)		(675)
Paid in year		2,661		1,241
Liabilities at end of year		570		798
Charge for year	72	2,433	49	1,364
Other research projects				
Liabilities at start of year		(399)		(360)
Paid in year		175		112
Liabilities at end of year		295		399
Charge for year	3	71	3	151
Scholarships	14	15	16	15
Travel	9	32	15	26
Total	**98**	**2,551**	**83**	**1,556**
Administration of research fellowships and other research projects		279		281
Research expenditure shown on Statement of Financial Activities		**2,830**		**1,837**

Further details of the research fellowships awarded and other research projects are available in the Research Report, published annually.

Financial details of the individual grants made are available from the Finance Department of The Royal College of Surgeons of England.

During the year, grants of £238,000 (2009: £423,000) were awarded for individuals at institutions with which members of Council are connected. These members of Council did not participate in the decisions to award the respective grants.

4 Staff and other expenditure

	2010	2009
Number of staff employed by the College at 24 June	290	291
	£000s	£000s
Staff costs in year to 24 June:		
Gross pay	8,908	9,125
Employer's statutory contributions	792	872
Employer's pension contributions	978	946
Total staff costs	10,678	10,943

At 24 June the number of employees receiving salaries in the following bands was as follows:

	2010	2009
£60,000 to £70,000	5	5
£70,001 to £80,000	5	4
£80,001 to £90,000	1	2
£100,001 to £110,000	1	1
£120,001 to £130,000	1	1

12 (2009: 12) of these employees are members of the USS pension scheme, while 1 (2009: 1) is a member of the NHS pension scheme.

	2010 £000s	2009 £000s
Included in Governance costs are:		
Auditors' remuneration – Audit fees – The Royal College of Surgeons of England	38	36
Auditors' remuneration – Audit fees – Hunter Trading Ltd	3	2

5 Tangible fixed assets

	FREEHOLD PROPERTIES £000s	FURNITURE, FITTINGS AND VEHICLES £000s	PLANT AND REFURBISHMENT £000s	COMPUTER EQUIPMENT £000s	CONSTRUCTION IN PROGRESS £000s	TOTALS £000s
Cost						
Balance 25 June 2009	3,352	679	19,430	2,047	927	26,435
Reclassification of assets	-	-	2,250	280	(2,530)	-
Additions	-	240	71	92	1,956	2,359
Balance 24 June 2010	**3,352**	**919**	**21,751**	**2,419**	**353**	**28,794**
Accumulated depreciation						
Balance 25 June 2009	-	562	10,103	1,429	-	12,094
Charge for year	-	65	1,376	292	-	1,733
Balance 24 June 2010	**-**	**627**	**11,479**	**1,721**	**-**	**13,827**
Net book values						
at 24 June 2010	**3,352**	**292**	**10,272**	**698**	**353**	**14,967**
at 24 June 2009	3,352	117	9,327	618	927	14,341

	UNRESTRICTED FUNDS £000s	RESTRICTED FUNDS £000s	ENDOWED FUNDS £000s	TOTALS 2010 £000s	TOTALS 2009 £000s
6 Debtors					
Taxation recoverable	6	1	-	7	19
Other debtors	2,685	263	-	2,948	3,558
Prepayments	90	-	-	90	98
	2,781	**264**	**-**	**3,045**	**3,675**
7 Cash and short-term deposits					
Cash in hand	16	-	-	16	13
Current and instant access accounts	1,314	2,543	282	4,139	4,465
Short-term deposit accounts	2,187	-	-	2,187	1,845
	3,517	**2,543**	**282**	**6,342**	**6,323**
8 Creditors					
Amounts falling due within one year					
Other creditors	5,496	-	-	5,496	4,476
Taxation and social security	88	-	-	88	347
Deferred income	3,141	-	-	3,141	3,629
	8,725	**-**	**-**	**8,725**	**8,452**
Amounts falling due after more than one year					
Other creditors	115	-	-	115	190
	115	**-**	**-**	**115**	**190**
9 Deferred income					
Balance brought forward	3,629	-	-	3,629	3.146
Income arising during the year	19,486	7,022	-	26,508	27,670
Released to Statement of Financial Activities	(19,974)	(7,022)	-	(26,996)	(27,187)
Balance carried forward	**3,141**	**-**	**-**	**3,141**	**3,629**

10 Investments	UNRESTRICTED FUNDS £000s	RESTRICTED FUNDS £000s	ENDOWED FUNDS £000s	TOTALS 2010 £000s	TOTALS 2009 £000s
Quoted securities at market value	22,590	1,641	25,862	50,093	41,766
Deposits with Newton Investment Management	2,023	29	441	2,493	3,592
Investment property at market value	1,770	-	-	1,770	1,650
Transfer of investments between funds	(2,121)	2,121	-	-	-
Market value	**24,262**	**3,791**	**26,303**	**54,356**	**47,008**
Movement in year					
Market value at 24 June 2009	19,913	4,373	22,722	47,008	57,720
Additions at cost	7,785	920	8,886	17,591	15,918
Disposals at sale price	(8,385)	(527)	(9,288)	(18,200)	(14,744)
Change in transfer of investments between funds	1,159	(1,159)	-	-	-
Net gain / (loss) on investments in year	3,790	184	3,983	7,957	(11,886)
Market value at 24 June 2010	**24,262**	**3,791**	**26,303**	**54,356**	**47,008**
Cost at 24 June 2010	20,012	1,473	22,183	43,668	44,359
Unrealised gain at 24 June 2010	4,250	2,318	4,120	10,688	2,649
Realised gains / (losses) on historic cost in year	**374**	**12**	**183**	**569**	**(2,700)**

At the year end, the market value of UK investments was £43,843,000 (2009: £40,243,000) and overseas investments was £10,513,000 (2009: £6,765,000).

As detailed in Note 1(i), the Common Investment Fund is incorporated into these financial statements.

Investment in subsidiary
Hunter Trading Limited – the College holds the entire issued £1 share capital of Hunter Trading Limited, which markets conference and residential facilities not required for the College's own use.

The results and financial position of Hunter Trading Limited have been consolidated in these financial statements on a line-by-line basis. Its income for the year was £1,738,000 (2009: £1,856,000), its expenditure was £1,663,000 (2009: £1,651,000), and the profit before tax of £75,000 (2009: £205,000) has been transferred to the College under a profit-shedding covenant. The net assets of Hunter Trading Limited were £1 (2009: £1).

11 Permanent endowments and other restricted funds

	PERMANENT ENDOWMENT FUNDS				RESTRICTED FUNDS			
	BALANCE 2009 £000s	INCREASES £000s	DECREASES £000s	BALANCE 2010 £000s	BALANCE 2009 £000s	INCREASES £000s	DECREASES £000s	BALANCE 2010 £000s
Dental Science Research Fund	1,686	300	8	1,978	472	73	318	227
Rank Chair Physics in Surgery	1,603	286	8	1,881	(312)	77	28	(263)
RCSE Cancer Research Fund	2,949	527	14	3,462	(53)	138	27	58
RCSE Biochemical Research Fund	627	112	3	736	69	30	74	25
Darlow Fellowship Fund	81	13	-	94	41	4	4	41
RCSE Research Fund	6,129	1,095	29	7,195	246	320	129	437
RCSE Education Fund	4,398	726	414	4,710	143	187	157	173
RCSE Museum Fund	12	2	-	14	84	15	17	82
Groves Bequest for Museum	350	62	2	410	4	18	-	22
M-W Johnson for Hunterian	625	132	3	754	315	26	66	275
George Qvist for Hunterian	350	64	2	412	3	17	17	3
Shrimpton Fund	-	-	-	-	-	28	-	28
RCSE Library Fund	1,375	246	6	1,615	8	65	63	10
RCSE Prize Fund	97	17	-	114	106	20	1	125
Preiskel Fund	-	-	-		18	2	-	20
HS Morton Travelling Fellowship	335	61	2	394	70	39	-	109
Sims Commonwealth Travelling Fellowship	106	19	-	125	57	8	-	65
Ethicon Travelling Fellowship	-	-	-	-	132	56	-	188
RCSE Scholarship Fund	85	16	-	101	34	12	16	30
Witt Fund	182	-	-	182	3	-	-	3
Modi Fund	-	-	-	-	349	138	60	427
Rishworth Fund for Annals	84	15	-	99	1	4	4	1
John Kinross Fund	137	25	1	161	111	6	-	117
Presidents Finch Fund	1,393	293	6	1,680	81	65	155	(9)
Blond McIndoe Fund	-	-	-	-	448	101	149	400
Faculty of Dental Surgery								
Commemoration Fund	111	20	1	130	1	6	6	1
Moser Trust	288	51	1	338	138	14	1	151

	PERMANENT ENDOWMENT FUNDS				RESTRICTED FUNDS			
	BALANCE 2009 £000s	INCREASES £000s	DECREASES £000s	BALANCE 2010 £000s	BALANCE 2009 £000s	INCREASES £000s	DECREASES £000s	BALANCE 2010 £000s
Faculty of General Dental Practice (UK)								
Research Fund	-	-	-	-	3	-	-	3
Surgical Research Fund	-	-	-	-	-	7	-	7
Cutner Legacy	-	-	-	-	-	299	94	205
Guyatt Legacy	-	-	-	-	-	166	80	86
Starritt Legacy	-	-	-	-	-	125	31	94
Clarke Legacy	-	-	-	-	-	100	19	81
Fletcher Legacy	-	-	-	-	-	70	-	70
Ethicon Research Fund	-	-	-	-	-	100	-	100
Dunhill Medical Trust	-	-	-	-	-	200	412	(212)
Far East HK Masonic Association	-	-	-	-	-	82	-	82
Curry Legacy Damage/Pain	-	-	-	-	-	302	-	302
Restricted Grants and Donations								
Cutner legacy for orthopaedics	-	-	-	-	299	-	299	-
Guyatt legacy for gastrointestinal diseases	-	-	-	-	165	-	165	-
Anatomy Project	-	-	-	-	225	-	83	142
OTTE Project	-	-	-	-	-	188	19	169
Starrit Research Fellowships	-	-	-	-	128	200	328	-
PCCT Transplant Fellowships	-	-	-	-	1,186	9	487	708
Post CCT Fellowship Project	-	-	-	-	105	28	88	45
JCST Selection Project	-	-	-	-	231	14	158	87
Hunterian Museum Project	-	-	-	-	1,392	-	259	1,133
Davies-Colley Lecture Room Project	-	-	-	-	122	-	24	98
Eagle Project	-	-	-	-	5,229	2,158	1,558	5,829
Other balances < £100,000	-	-	-	-	2,508	2,089	2,439	2,158
TOTAL	**23,003**	**4,082**	**500**	**26,585**	**14,162**	**7,606**	**7,835**	**13,933**

The negative balances on funds are caused by providing in full for notified future expenditure and will be funded from future streams of investment income.

The funds are for the purposes as described in their title.

The increases for the endowed funds are represented by increases in investment market value. There was also a total of £99,000 transferred from restricted funds (see Transfers on page 47). The decrease in endowed funds is represented by investment management charges.

There was also a further loan of £400,000 authorised by Charity Commission schemes, from the Education endowed fund to the Education restricted fund (see Transfers on page 47).

Transfers
Transfers from restricted funds to endowed funds were authorised by Charity Commission Schemes, as follows:

1. MacRae–Webb-Johnson Fund: In 2003–04 £600,000 was transferred from the MacRae–Webb-Johnson's endowed fund to its restricted fund to support the Hunterian Museum Project. This sum is to be replaced by income arising on the MacRae–Webb-Johnson's restricted fund at the rate of £24,000 a year for 25 years. The sixth transfer of £24,000 was made in 2009–10.

2. President's Finch Fund: In 2006–07 £1,100,000 was transferred from the President's Finch's endowed fund to its restricted fund to support the Eagle Project. This sum is income arising on the President's Finch's restricted fund at the rate of £55,000 a year for 20 years. The third transfer of £55,000 was made during 2009–10.

3. Education Fund: In 2008–09 £400,000 was transferred from the Education endowed fund to its restricted fund to support the Eagle Project. This sum is to be replaced by income arising on the Education restricted fund at the rate of £20,000 a year for 20 years. The second transfer of £20,000 was made during 2009–10. In 2009-10 an additional £400,000 was transferred from the Education Fund to further support the Eagle Project. This sum is to be replaced by income arising on the Education restricted fund at the rate of £16,000 a year for 25 years. The first payment will occur in 2010/11.

12 Unrestricted funds

	2010 £000s	2009 £000s
Designated funds		
Represented by tangible fixed assets	7,632	7,484
'Capital' designated as necessary to provide income to support the College's charitable activities		
Brought forward	14,000	22,000
Increase/(decrease) in year	3,000	(8,000)
	17,000	14,000
Total designated funds	**24,632**	**21,484**
Working reserves – The College and faculties	**4,852**	**4,210**
Total unrestricted funds	**29,484**	**25,694**

The basis of maintaining the 'capital' part of the designated funds is to hold sufficient resources to generate a continuous flow of income to help support the cost of charitable activities within an overall strategy of ensuring the long-term financial viability of the College. The increase of £3.0 million (2009: decrease £8.0 million) derives in part from the increase in the market value of unrestricted funds investments in the year to provide an amount approximately equivalent to 9–12 months of operational expenditure.

Working reserves are funds held for operational purposes of the College and its two dental faculties. Approximately £382,000 (2009: £372,000) of the available funds is held by the divisions of the Faculty of General Dental Practice (UK).

13 Pension schemes

The three pension schemes in which the College participates are defined benefit schemes but it is not possible to identify its share of the underlying assets and liabilities as required by the Financial Reporting Standard No. 17 – Retirement Benefits. Accordingly, the College accounts for pension costs in relation to these schemes as if they were defined contribution schemes.

Of the College's 290 employees (2009: 291), 136 (2009: 142) are members of the Universities Superannuation Scheme (USS), 49 (2009: 45) are members of the Superannuation Arrangements of the University of London (SAUL) and 5 (2009: 5) are members of the NHS Pension Scheme. All three are defined benefit schemes, externally funded and managed by independent trustees. They are contracted out of the State Earnings-Related Pension Scheme.

USS: The latest triennial actuarial valuation of the scheme was at 31 March 2008. This was the first valuation for USS under the new scheme-specific funding regime introduced by the Pensions Act 2004, which requires schemes to adopt a statutory funding objective, which is to have sufficient and appropriate assets to cover their technical provisions. The actuary also carries out a review of the funding level each year between triennial valuations and details of his estimate of the funding level at 31 March 2010 are also included in this note.

The triennial valuation was carried out using the projected unit method. The assumptions which have the most significant effect on the result of the valuation are those relating to the rate of return on investments (ie the valuation rate of interest), the rates of increase in salary and pensions, and the assumed rates of mortality.

It was assumed that the valuation rate of interest would be 6.4% per annum, salary increases would be 4.3% per annum and pensions would increase by 3.3% per annum.

Standard mortality tables were used as follows:

Male members' mortality	PA92 MC YoB tables – rated down 1 year
Female members' mortality	PA92 MC YoB tables – no age rating

At the valuation date, the value of the assets of the scheme was £28,842.6 million and the value of the scheme's technical provisions was £28,135.3 million indicating a surplus of £707.3 million. The assets therefore were sufficient to cover 103% of the benefits which had accrued to members after allowing for expected future increases in earnings.

The institution contribution rate required for future service benefits alone at the date of the valuation was 16% of pensionable salaries and the trustee company, on the advice of the actuary, agreed to increase the institution contribution rate to 16% of pensionable salaries from 1 October 2009.

Since 31 March 2008 global investment markets have continued to fall and at 31 March 2010 the actuary has estimated that the funding level under the new scheme-specific funding regime had fallen from 103% to 91%. Compared to the previous 12 months, the funding level has improved from 74% (as at 31 March 2009) to 91%. This estimate is based on the funding level at 31 March 2008, adjusted to reflect the fund's actual investment performance over the two years and changes in market conditions (market conditions affect both the valuation rate of interest and also the inflation assumption which in turn impacts on the salary and pension increase assumptions).

USS is a 'last man standing' scheme so that in the event of the insolvency of any of the participating employers in USS, the amount of any pension funding shortfall (which cannot otherwise be recovered) in respect of that employer will be spread across the remaining participant employers and reflected in the next actuarial valuation of the scheme.

The next formal triennial actuarial valuation is due as at 31 March 2011. The contribution rate will be reviewed as part of each valuation and may be reviewed more frequently.

The level of contribution due by the College in the year was 16% of pensionable salaries (effective from 1 October 2009). The College's total pension cost for this scheme in the year to 24 June 2010 was £809,569 (2009: £768,882).

SAUL: SAUL is subject to triennial valuations by professionally qualified and independent actuaries. The last available valuation was carried out on 31 March 2008 using the projected unit credit method. The following assumptions were used to assess the past service funding position and future service liabilities:

Valuation method – projected unit	Past service	Future service
Investment return on liabilities:		
before retirement	6.9% pa	7.0% pa
after retirement	4.8% pa	5.0% pa
Salary growth (excludes promotion increases)	4.85% pa	4.85% pa
Pension increases	3.35% pa	3.35% pa

The actuarial valuation applies to SAUL as a whole and does not identify surpluses or deficits applicable to individual employers. As a whole, the market value of SAUL's assets was £1,266 million representing 100% of the liability for benefits after allowing for expected future increases in salaries. Based on the strength of the employer covenant and the trustee's long-term investment strategy, the trustees and the employers agreed to maintain employer and member contributions at 13% of salaries and 6% of salaries respectively following the valuation.

The next formal actuarial valuation is due at 31 March 2011 when the above rates will be reviewed.

The level of contribution due by the College in the year was 13% of pensionable salaries. The College's total pension provision for this scheme in the year to 24 June 2010 was £135,573 (2009: £136,040).

NHS: The College's total pension cost in respect of the NHS Pension Scheme in the year to 24 June 2010 was £31,792 (2009: £40,858). The level of contribution due by the College in the year was 14%.

14 Transactions with trustees

No trustees receive any fees or honoraria.

Members of Council claim travelling, subsistence and accommodation costs in respect of Council or committee meetings or for attending meetings on behalf of the College, and the total of such expenses reimbursed to all 26 trustee members of Council in the year was £85,481 (2009: £101,213 to all 26 trustee members of Council).

15 Legacy income

The major legacies or gifts that have been notified to the College but not included in the financial statements, as they do not meet the income recognition criteria of entitlement, measurement and certainty, are:

	ESTIMATED AMOUNT £000s
Notified on or before 24 June 2010	
Purpose:	
The main appeal of the College	446
For medical research and education	155