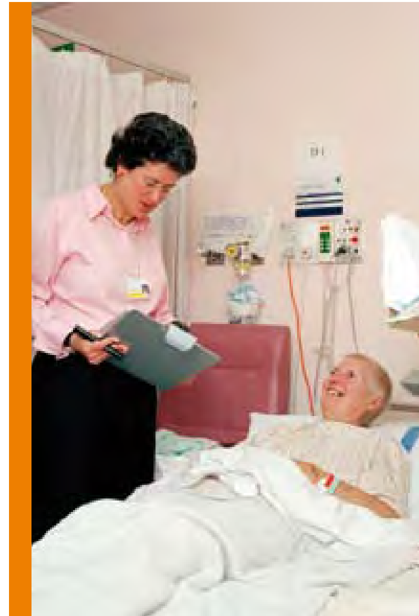
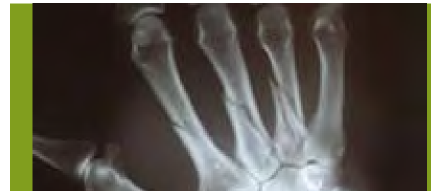
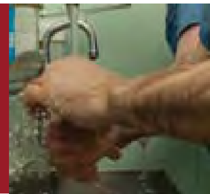
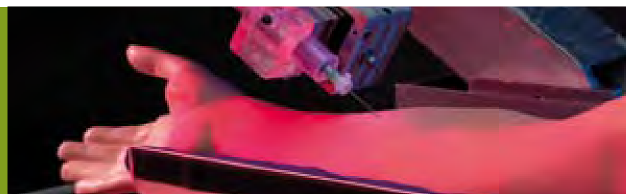




Annual Report 2008–2009





Annual Report 2008–2009

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.

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Foreword from the President

The College has had a busy and eventful year. The major item on the political front was the publication of a joint document with The Royal College of Anaesthetists on how the 48-hour working week, demanded from 1 August 2009 by the European Working Time Directive (EWTD), could be introduced without detriment to patient safety and standards of surgical training. The conclusion was that it could not be delivered in the NHS without major detriment to both. In the College's view, the only solution was to seek an opt-out for surgeons, allowed under European law, to an hours limit based on an 'ideal working week', as defined by the two trainee organisations, the Association of Surgeons in Training and the British Orthopaedic Trainees Association. This led to a political and media campaign unprecedented in the 700-year history of the College, only possible because of near unanimous support from surgeons of all grades.

During the year, the College began to implement a strategy of supporting surgeons in the workplace. We piloted the appointment of a senior surgeon in each strategic health authority in England and introduced the role of director of professional affairs in Wales and Northern Ireland. The regional representatives of the nine specialty associations, who will be endorsed by the College as regional specialty advisors, will also provide advice. The new system is in addition and in parallel to the existing networks of heads of the schools of surgery and programme directors. The new roles are required partly to provide specialty advice to NHS commissioners, which is sadly lacking, and also to support surgeons in the revalidation process, which is due to begin in 2011.

Revalidation, which will require doctors to demonstrate their continuing fitness to practise at least every five years in order to retain their licence, is a concern not only to

all practising surgeons but also to employers and to the General Medical Council (GMC), which carries the ultimate responsibility. I am pleased to say that during the year the specialty associations, facilitated by the College, wrote the standards against which surgeons will be revalidated, the setting of which is a statutory royal college responsibility. The College wishes to see a simple workable system, based on enhanced appraisal, and discussions with the GMC and NHS employers made it likely that there will be pilots of such a system in 2010.

A further development of College activity is in the field of patient safety, something in which the College has been involved since its earliest days. Our determination to set the highest possible standard of practice and training is part of this, as is our advice to the government and other bodies on matters such as the configuration of surgical services and the dangerous effects of legislation such as the EWTD. A third area is in the detail of surgical processes and the National Patient Safety Agency has set up a clinical board for surgical safety, which I chair in my capacity as President of this College. One of the first items it considered was the World Health Organization *Surgical Safety Checklist*, endorsed by Council in the previous year, which I have described as a 'no-brainer'. It addresses the fundamentals such as having the correct patient in the anaesthetic room: basics that, if ignored, could lead to disaster.

An important milestone this year was the opening by Her Royal Highness the Princess Royal in March 2009 of the second phase of the Eagle Project, the state-of-the-art surgical skills unit occupying the fourth floor of the College. This is an opportunity to thank the many individual and corporate benefactors who supported us so generously in this ambitious but essential project. The final phase was under way at the end of the College year 2008–2009.

In January 2009 Mr Alan Bennett joined us from a senior rank in the Royal Navy as our Chief Executive. He has our good wishes for every success in the post, which involves managing over 300 staff and a turnover of more that £25 million pounds.

It is impossible in a short foreword to do justice to the many activities of the College, all in support of the 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 first annual report as Chief Executive of The Royal College of Surgeons of England and take pride in reviewing our achievements in the past year.

The Royal College of Surgeons is a professional body that exists to set the highest possible standards for surgical practice and training, leading to the delivery of safe and high-quality patient care.

During 2008–2009 the College has worked hard towards promoting and protecting the interests of patients. Our commitment to patient safety is underpinned through the examinations of our trainees, as well as the teaching of our trainers. In 2008 we worked with our sister colleges to revise the membership examination (MRCS), to reflect the new surgical training requirements introduced in August 2007. This exam ensures that surgical trainees acquire the knowledge, skills and attributes required for the completion of core training in surgery. We continued to develop the Intercollegiate Surgical Curriculum Programme that underpins surgical training throughout the country to meet the needs of trainees and trainers. The development of a new clinical skills unit in the College, with a mock operating theatre and state-of-the-art simulator, will enable trainees and surgeons to develop their operative and teamwork skills. The work of our Patient Liaison Group furthers the College's commitment to patient and public inclusion, and the group contributed to government and College publications, consultations and policy initiatives.

The College's pursuit of excellence in the delivery of surgical care is constant and the research undertaken by our research fellows, as well as in partnership with other bodies, continued successfully throughout 2008–2009. We continued to offer a full programme of continuing professional development and educational activities for surgeons at all levels and across all specialities, 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 this year the Hunterian Museum attracted over 45,000 visitors.

The College has had to re-examine its future workload in response to the current economic climate and the budgeting of the College has been revised to ensure that it will continue to operate effectively in the coming years.

In conclusion, I would like to thank all members of Council and staff for helping the College to move towards achieving its aims. I look forward to us pursuing these through

the further development of the business planning process, so that we can continue to support surgeons to achieve and maintain the highest standards of surgical practice and patient care.

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 directly impacts 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 deliver 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's 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.

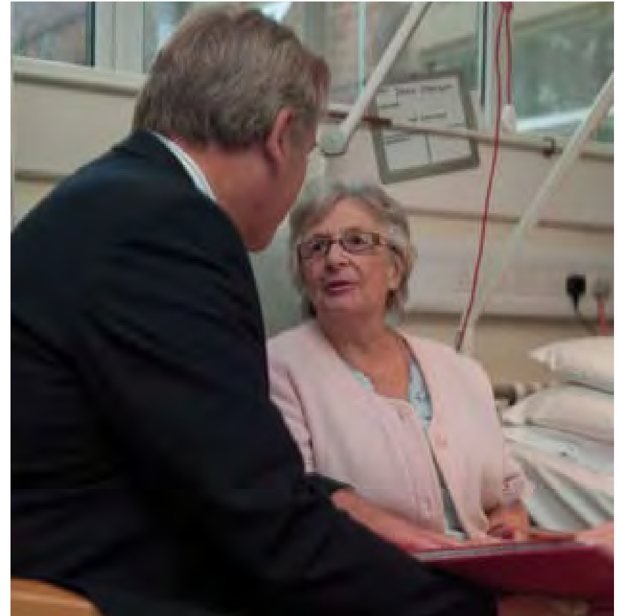
Assessing the outcomes of operations

The public benefit of collecting outcomes of operations is to assess the quality of the surgical treatment and overall care patients receive. This will help the NHS to identify areas for improvement and track whether new developments are producing positive results.

The College carried out a feasibility study in 2008 that demonstrated that large scale patient-reported outcome measures (PROMs) collection could work. As a result, in 2009 the Department of Health (DH) set up a national system of PROMs for hip replacements, knee replacements, groin hernia surgery and varicose vein surgery. Patients are asked questions about their health and quality of life before treatment and then again after recuperation. This information can be used to assess the quality of the surgical treatment and overall care they received. This information will help the NHS to identify areas for improvement and the effectiveness of one treatment over another.

The College's Clinical Effectiveness Unit (CEU) is now undertaking an audit of elective surgical treatment (hip and knee replacement, hernia repair or varicose surgery) comparing outcomes reported by patients treated in NHS hospitals, NHS treatment centres, independent sector treatment centres and private hospitals. This 'patient outcomes in surgery' audit focuses on PROMs as well as on surgeon-reported measures. This audit, funded by DH, started in October 2007 and data collection is taking place between April 2008 and March 2010, with a final report due to be published in October 2010.

The CEU supports the data analysis for the National Joint Registry, which was set up by DH and the Welsh Assembly Government to collect information on all hip and knee replacement operations and to monitor the performance of replacement hip and knee



joints. This information helps orthopaedic surgeons compare the effectiveness of different types of prosthesis and decide which to use on patients. The 2009 report highlighted that, with the exception of hip resurfacing, elderly patients had lower revision rates following primary hip replacement than younger patients and women had lower revision rates than men. For resurfacings, these trends were reversed and revision rates were higher for elderly patients and women. This information will help ensure that patients receive the best type of prosthesis for their circumstances.

Within its portfolio, the CEU is continuing with the National Mastectomy and Breast Reconstruction Audit, which will assess and improve the quality of care provided to women with breast cancer undergoing mastectomy and breast reconstruction. It is important that women with breast cancer who have a mastectomy are offered the choice of breast reconstruction immediately, as this helps reduce the number of operations needed and minimises the psychological impact of a mastectomy. One in five women with breast cancer in England now has an immediate reconstruction at the time of her mastectomy, compared to one in nine in 2006. The CEU project has contributed to the improvement in reconstructive surgery rates following a mastectomy.

The National Oesophago-Gastric Cancer Audit, another national audit in which the CEU plays a leading role, has demonstrated

National audit projects in which the CEU is involved:

- » 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 (DH PROMs programme)
- » Mastectomy and breast reconstruction
- » Oesophago-gastric 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

that the pattern of referral from general practice to hospital for patients with this type of cancer varied by region. The proportion of patients who are referred by their GP using non-urgent referral pathways varied from 13% to 66% among the 30 regional cancer networks in England and Wales. This means that the cancer diagnosis for some may be delayed, which is linked to a poorer chance of survival.

Future plans

- » We will strengthen our methodological work on risk adjustment, continuous data collection and patient-reported and surgeon-reported data.

Measuring and assessing standards

We are developing standards by which surgeons will be measured and assessed so that they can demonstrate that they are delivering high-quality care to patients.

We have been preparing for the introduction of a system of revalidation for the medical profession, which will require doctors to demonstrate their continuing fitness to practise at least every five years in order to retain their licence. This system is still being developed in conjunction with the specialty associations, the Academy of Medical Royal Colleges (AoMRC), the GMC and DH, and is due to be introduced over the next two to

three years. In collaboration with specialty associations, we have developed standards by which surgeons will be measured and assessed. We are now putting the standards out to consultation and making required changes before submitting them to the GMC for approval. By formalising and bringing together standards for revalidation, surgeons will be able to demonstrate that they are delivering high-quality care to patients.

The College is committed to providing support to surgeons through this process. We are developing an online portfolio for surgeons to gather supporting information for their appraisal (the key assessment mechanism within the revalidation process). As part of this online portfolio we are developing continuing professional development (CPD) recording systems that we hope will, in the future, include automatic recording by CPD event organisers. We will also provide support to surgeons through existing and enhanced advice and support services. Most of this support will be delivered locally through our regional professional affairs network.

The CEU is working on a two-year project, funded by the AoMRC, to assess the value of administrative data (eg hospital episode statistics) for revalidation and to support the measurement of outcomes of specific procedures and across disease pathways. It hopes to enable the measurement of both multi-professional teams and the performance of individual clinicians.

Future plans

- We will continue to support the development and implementation of revalidation including setting up pilots of the process.
- We will support consultant surgeons and non-training grades both to meet and to demonstrate the required standards of professional practice for revalidation.

Reviewing surgical services

The Invited Review Mechanism (IRM) supports surgeons and trusts to maintain high standards of patient care and help them to provide high-quality surgical services.

Through the IRM, the College provides an independent, confidential and professional review process to help trusts determine whether there is a cause for concern about the performance of an individual surgeon or surgical unit and makes recommendations for improvement where necessary. The IRM also provides an independent view to support trusts in deciding how to structure their services for the future.

Future plans

- We will support hospitals to deal with performance issues through the IRM.
- We will continue to develop the IRM in accordance with the requirements of revalidation.

The IRM has an important role in maintaining standards and supporting surgeons. This role is likely to expand with issues caused by revalidation and recertification. All surgical specialties have a cohort of consultants, all of whom are trained in equality and diversity. It is a privilege to be invited into another surgical department and help to unlock either clinical issues or interpersonal difficulties that have not been resolved by local processes. The reviews are not without their challenges and the role of the lay reviewer has proved invaluable by adding a completely different perspective to issues and bringing experience from outside clinical work. The impact of the reviews is confidentially monitored by the College. Trying to help manage these difficult situations is both interesting and professionally satisfying but most of all provides a benefit for patients.

Kate Evans, Consultant ENT Surgeon, clinical reviewer for the IRM

Sitting as a lay member of review panels is a particularly rewarding experience. As a lay person it has invariably been an educational experience for me, one helped considerably by the kindness and consideration of professional members. Ignorance is not usually considered a virtue, yet lay members' very lack of specific knowledge is often the source of their most valuable contribution: the spur to asking for clarification, making explicit those things that might otherwise be left unspoken.

Steven Ainsworth, lay reviewer for the IRM

The Patient Liaison Group

Improving standards of patient care remains the focus of the work of the College. The Patient Liaison Group (PLG) provides a formal mechanism for patient representation and encourages 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.

The PLG campaigned for lay involvement in the College membership examination (MRCS), which surgical trainees have to pass in order to move into higher surgical training. As a result, the College introduced lay examiners to assess the communication skills part of the exam alongside a surgeon examiner, and a number of lay members of the PLG are involved as assessors.

Lay members of the PLG are also contributing to the College's work in setting out the standards required for surgeons to be revalidated to ensure their fitness to practise.

The PLG addressed the All-Party Parliamentary Group for Patient Safety, chaired by Dr Howard Stoate MP, to discuss the PLG's key areas of concern with regard to patient safety such as hospital-acquired infections and the impact of targets on how care is delivered. It also gave written evidence to the Health Select Committee's inquiry on patient safety. The PLG wrote to the Secretary of State for Health about its concerns with the loss of training time for surgeons and effects on continuity of care for patients with the introduction of a shorter working week for surgeons in August 2009.

The Patient Liaison Group provides a direct public voice within the College and is represented on many work groups, including Council.

Left:
Lesley Bentley, Lay Chair of the PLG, at the Labour Party conference

Providing Leadership on Health

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

The College is working to improve standards of surgical services and the way that they are delivered for the benefit of patients. In order to achieve high standards of patient care the College believes that surgeons should have the flexibility of extending their working hours and not be restricted to the 48-hour week imposed by the European Working Time Regulation (EWTR) to avoid multiple handovers and low levels of cover.

John Black speaking at the Conservative Party conference

We have campaigned vigorously for a sectoral opt-out to the EWTR, which currently limits surgeons' working hours to 48 hours a week. Our survey of surgeons has demonstrated that with current staffing levels it is impossible to implement a 48-hour working week and maintain the current level of service and access for all patients. It found that a significant reduction in working hours would have a considerable impact on both service delivery and training. We have found that the shift system for 48 hours 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 patient throughout surgical treatment. The College is therefore calling for all surgeons, including those in training, to be exempt from the restrictions of the EWTR in order to allow them to have the flexibility of extending their working hours up to a maximum of 65 hours per week, with appropriate rest breaks so that hospitals are safely staffed to provide high-quality care for all patients.

John Black, the President, has been very vocal on the College's concerns of the impact of the new working hours on patient safety. He met the then Secretary of State for Health, Mr Alan Johnson MP, the Shadow Health Secretary, Andrew Lansley MP, and Welsh Health Minister, Edwina Hart AM;

Two years ago, the Royal College of Surgeons was warning about what was going to happen and offering some solutions. Today, it is again expressing warnings and offering ideas and solutions to the Secretary of State.

Andrew Lansley MP, Shadow Health Secretary, speaking in Parliament on the EWTR on 10 March 2009

made a number of media appearances; was interviewed by many journalists; and voiced our concerns at political party conferences.

In January 2009, John Black, gave evidence to the Health Select Committee as part of its inquiry into patient safety. He stressed that the College is committed to improving patient safety in all aspects of surgery from current practice to new and emerging techniques. He emphasised the importance of teamworking and surgeons having experience of working in clinical teams both in theatre and on the ward. We support the findings of the Health Select Committee that patient safety should be at the top of the health agenda and over the past year the College has focused on improving surgical care for patients.

The College endorsed the World Health Organization (WHO) *Surgical Safety Checklist* and called for its full implementation across the health service. The checklist identifies three phases of an operation and in each phase it must be confirmed that the surgical team has completed the task on the list before it proceeds.

John Black chairs the Clinical Board for Surgical Safety, which has representatives from the NHS, nursing and other professional organisations and seeks to shape the development of guidance in response to the National Reporting and Learning Service (NRLS). The NRLS collates all patient safety incidents and near-miss reports from NHS organisations in England and Wales.

The College believes that good teamworking plays an important part in positive outcomes in surgery for patients. We have therefore developed a training course entitled *Patient Safety in Theatre Teams – A Practical Approach to Human Factors* to teach all members of the theatre team how to improve communication and develop leadership skills. We prepared a training video entitled *The Journey* on the surgical team's responsibilities and the use of the surgical safety checklist. This includes theatre-based scenarios designed to help each individual team member work more effectively with his or her colleagues and as a team.

We have raised concerns about overcrowding in hospitals leading to poor cleaning, which encourages the spread of infections such as MRSA and *C difficile*. Data on occupancy rates is usually only available to patients on a centre-by-centre basis. We would like to see such data made available for individual wards to help patients choose where to go for surgery. We believe that there should be a maximum bed occupancy rate of 82% and adequate single room facilities to help limit the incidence of healthcare-associated infections.

In autumn 2008, for the second year running, the College participated in a full programme of events at the three political party conferences. Central to this was a series of seminars at each conference on the collection and use of outcome data, entitled *Making outcomes public: who benefits?* This was arranged in partnership with The Health Foundation and The Royal College of Midwives. The College was represented on the panel at each event together with Lesley Bentley, Lay Chair of the PLG, and a representative from each political party and partner organisation.

Paediatric surgery

The College continues to call for a long-term solution for paediatric surgery in the UK. There needs to be greater local provision of non-specialist surgical operations such as those involving hernia or drainage of an abscess. In many cases children are being transported hundreds of miles to receive minor surgery when it would be far better to be treated in properly equipped, local hospitals. The knock-on effect is that specialist units are being overwhelmed with minor cases that inhibit them from caring for children with rare and life-threatening conditions. We believe that there should be local care for appropriate cases and that simple paediatric surgery could be maintained in local hospitals by employing surgeons with an interest in paediatric surgery, after relevant training. We have warned that if a solution is not found then local provision may cease in some areas.

The decontamination of surgical instruments

Decontamination facilities need to operate to the highest standard, ensuring both effective decontamination and a guaranteed supply of instruments to operating theatres. Additionally, these facilities need to be readily available in order to provide immediate decontamination where necessary, for example in the event of a dropped instrument or implant that cannot be replaced. The College conducted a survey of 258 surgeons that highlighted that surgical instruments needing to be sterilised are not being returned in the required condition or in adequate time before operations are due to be carried out and that as a result operations are being cancelled. The College has therefore been calling for a safe decontamination service for patients and recommends the retention of on-site decontamination services and an additional set of surgical instruments for every operation. We put forward our concerns to DH in a meeting.

Future plans

- » We will carry out a survey to assess the implementation and effects of the EWTR on surgeons and trainees.
- » We will continue to put forward the case for an opt-out clause from the EWTR for the surgical workforce.
- » We will actively promote the WHO *Surgical Safety Checklist* to our members.
- » We will continue to call for the retention of on-site decontamination services and an additional set of surgical instruments for every operation.

Supporting Surgeons through Education and Training

Our new clinical skills unit with a mock operating theatre will enable trainees and surgeons to develop their operative and teamwork skills.

Surgical training

The clinical skills unit was opened by HRH The Princess Royal on 18 March 2009 and houses state-of-the-art technology that will revolutionise training for surgeons and members of the many other professions who work in theatres. This complements the existing Wolfson Surgical Skills Centre, a purpose-built surgical workshop in which participants can undertake hands-on cadaveric dissection and operating.

Within the operating theatre built in the new unit, team interaction and role-playing can be recorded and video debrief techniques employed to enhance the learning experience. For the first time, we are able to develop and teach teamwork skills by using mannequins and multimedia facilities. In line with our aspiration to remain at the forefront of surgical education, we can now make the most of technological innovation, including endoscopy and computer-aided navigation. This new unit delivers the infrastructure and facilities needed to:

- teach decision making and team skills;
- evaluate new surgical equipment and techniques; and
- develop new educational techniques and technology for on-site and remote learning.

At specialty level, anatomy remains the fundamental component of teaching and assessment. Anatomy teaching has been strengthened and extended within the College and we have a surgical workshop with nine specially designed dissection tables, enabling 36 participants to undertake hands-on cadaveric work. A new anatomy project has been developed in conjunction with the London Deanery and provides anatomy teaching for all their core surgical trainees.

We provide a well-established training course, *Care of the Critically Ill Surgical Patient®* (*CCrISP®*), which is delivered at the College and regionally. This course teaches trainees vital skills for the recognition and management of the deteriorating patient but is not currently mandatory. Unfortunately, participation has decreased dramatically since trainee study leave budgets were cut drastically two years ago. Trainees generally now fund the cost of this and other vital courses themselves. Improving patient safety will not happen without investment and we believe the funding of *CCrISP®* and other

vital training courses must be restored for all surgical trainees, particularly as the EWTR sharply reduces training time.

The Intercollegiate Surgical Curriculum Programme (ISCP) is the surgical curriculum for the nine surgical specialties introduced in August 2007. 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 the trainee's annual review process and the award of the Certificate of Completion of Training (CCT).

Future plans

» We are currently building a seminar suite to accommodate one-to-one training and assessment for relevant course components, such as recording facilities for communication skills workshops and video conferencing facilities. This area will comprise two seminar areas, a lecture theatre for 50 participants and a multi-skills area.

» We will develop further teaching materials, models and prosections to support the core surgical anatomy programme.

» We will continue to deliver, develop and evaluate the ISCP. Technical priorities include improvements to the logbook, navigation, searching, personalisation, registration and evidence collection, and validation.

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. As well as enrolling trainees, monitoring their progress and making recommendations when they are ready for the CCT, we have continued to evaluate applications for specialist registration from surgeons who do not have the CCT (awarded to trainees in the UK following completion of a recognised training pathway) but who have acquired equivalent training, qualifications or experience. In December 2008, the JCST produced standards for surgical training to supplement the Postgraduate Medical Education and Training Board's (PMETB's) generic standards for training. The specialist advisory committees (SACs) for each of the nine surgical specialties have continued to work with deaneries to develop and maintain standards across surgical training. The JCST has also been developing a 'good practice toolkit' for selection of surgical trainees, providing good practice tools, models and techniques for those responsible for selection to use.

The JCST conducts a survey of all surgical trainees at the end of their surgical placements. This asks trainees to evaluate and comment on the quality of the placement against JCST training standards and their engagement with the curriculum. The findings are reported to, and acted on by, the schools of surgery, the bodies responsible for training placements. The findings are also considered by the SACs, who oversee the quality of training in individual surgical specialties. The public benefit is that we are working with the schools of surgery to improve the quality of surgical training by identifying and addressing where training falls below the established standards.

The JCST training interface groups oversee advanced training in very complex areas involving more than one specialty. They allow exceptional senior trainees, who go through a national selection procedure, to develop their skills in highly specialised areas such as cleft lip and palate, head and neck, breast, and hand and cosmetic surgery to meet the needs of patients with complex diseases and deformities. These highly trained surgeons will fulfil the workforce needs of the future.

Davinder Sandhu, Postgraduate Dean/ Head of Education, NHS Education South West, Severn Deanery

Future plans

- » We will continue to develop an effective process for working in partnership with PMETB and prepare for the merger of PMETB with the GMC in April 2010.
- » We will publish a 'good practice toolkit' for selection, providing good practice tools, models and techniques for those responsible for the selection of surgical trainees.

The revised membership examination

The membership examination of the surgical royal colleges (MRCS) ensures that surgical trainees have acquired the knowledge, skills and attributes required for the completion of core training in surgery.

The intercollegiate MRCS is designed for candidates in the generality part of their specialty training. It is a crucial milestone that must be achieved if trainees are to progress to specialty surgical training as defined by the nine surgical SACs. The purpose of the MRCS 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.

No curriculum should ever be fixed and immutable, and assessments and exams must therefore be constantly reviewed and refined to reflect the changes that take place. The MRCS exam will continue to evolve.

Kevin Sherman, Chair of the Intercollegiate Quality Assurance sub-group

The format of the MRCS examination for trainees was revised in October 2008, to reflect the new surgical training requirements introduced in August 2007. For the first time, 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. This forms part of the objective structured clinical examination (OSCE) and 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. In 2008–2009 55% of trainees chose to take their MRCS examination at the English College, a significant increase compared with the previous year.

The MRCS exam is quality assured by all the surgical royal colleges to ensure that it tests the skills and aspects of knowledge as set out in the syllabus and that it tests these 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 English College and have introduced an online examination entry system for candidates.

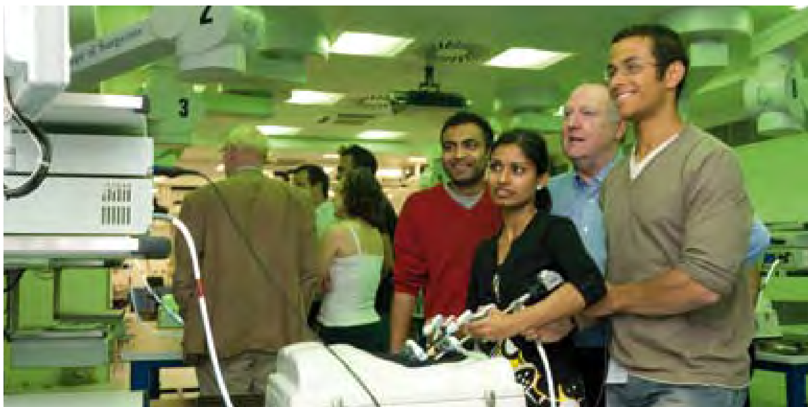
Future plans

» The OSCE will be revised to have more basic science and clinical components.
» We will open new overseas exam centres for the MRCS.
» We will continue to introduce improvements to our online application process.

Training courses

The College held 662 courses with 8,953 delegates in 2008–2009. We deliver a number of courses for trainees and consultants aimed at developing safe surgical practice and the management of trauma and the critically ill surgical patient. We also run the multi-disciplinary military operations surgical training course for the UK armed forces. The College continues to deliver courses at regional centres, including:

» *Advanced Trauma Life Support®* (*ATLS®*) (recently updated)
» *Intercollegiate Basic Surgical Skills*
» *CCrISP®*
» *Core Skills in Laparoscopic Surgery*
» *Specialty Skills in Emergency Surgery*
» *Training the Trainers (TtT)*
» *Training and Assessment in Practice (TAIP)*
» *Core Surgical Sciences*



I'm using the lessons on negotiation skills, cooperation from colleagues and approaching the right people to try to develop various services pertaining to my specialty and personal development. I feel that above all the course has made me feel empowered to effect change to improve service delivery and meet personal objectives. I would recommend the course most highly.

A participant on the leadership skills course, autumn 2009

The *Core Skills in Laparoscopic Surgery* course has now been regionalised with over 20 centres having run this course at least once with an average attendance of 12 participants per course. The course is designed for surgeons in the early stages of training and teaches the skills to perform gall bladder removal, appendicectomy and laparoscopic repair of perforated ulcers. It introduces keyhole suturing, which was previously considered an advanced skill, to early surgical trainees.

Peter Sedman, Tutor in *Minimally Invasive Surgery*

In 2008 the London Deanery commissioned the College to provide a programme to develop the leadership skills for staff grade and associate specialist (SAS) surgeons within the deanery. SAS surgeons work at various career grades in hospitals and at times will be the lead surgeon in theatre, needing to display leadership qualities as part of the theatre team. This course was also made available to other medical professionals including paediatricians, psychiatrists, gynaecologists, ophthalmologists and obstetricians. This expansion encouraged greater understanding of issues between the various disciplines.

Over 85 courses were offered across all the specialties and sub-specialties over the year. The College continues to share its expertise with surgical communities across the world. In particular, basic surgical skills courses, *CCrISP®* and *TtT* are delivered internationally in countries including Germany, Norway, Sweden, Malta, Australia and Egypt.

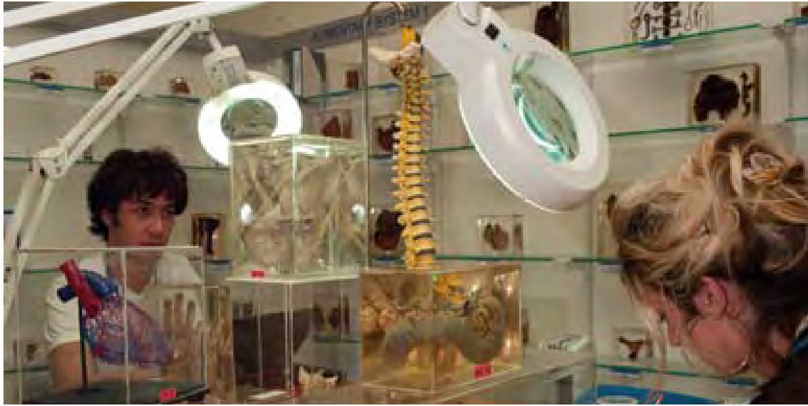
The Centre for Evidence in Transplantation is a joint operation between the College and the London School of Hygiene and Tropical Medicine of the University of London. In March 2009 it ran an evidence in transplantation course aimed at young professionals actively involved in organ and tissue transplantation who want to increase their skills in evidence-based decision making.

The *Operative Skills in Neurosurgery* course at the College is unique. You learn procedures on human cadavers, just like the real thing. My practical experience of procedures gained here will be useful when explaining to patients and relatives. I definitely plan to attend further courses at the College in the future as I can learn key skills in a controlled environment with a lot of help.

Gulam Zilani, surgical trainee

Future plans

- We will develop new courses using the team skills training theatre, eg theatre access and etiquette awareness courses.
- We will implement both the *Patient Safety in Surgical Teams* and *Legal Aspects of Surgery* courses at regional level.
- We will develop a follow-on advanced laparoscopic skills training course.
- We will create and develop links with overseas centres to improve standards.



I am certain that the extensive collections at your museums contain information that is yet to be appreciated by the scientific community. The range of diversity of holoprosencephaly in animal species is just one example. I know of no place in the world where one can examine such a large collection of specimens. The museums are thus a treasure for researchers and I thank you, your staff and the College for many efforts in maintaining and expanding the collections.

Joseph Siebert, Professor of Pathology and Paediatrics, University of Washington School of Medicine

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 3,889 visitors in 2008–2009 compared to 1,452 in 2007–2008.

Supporting aspiring surgeons

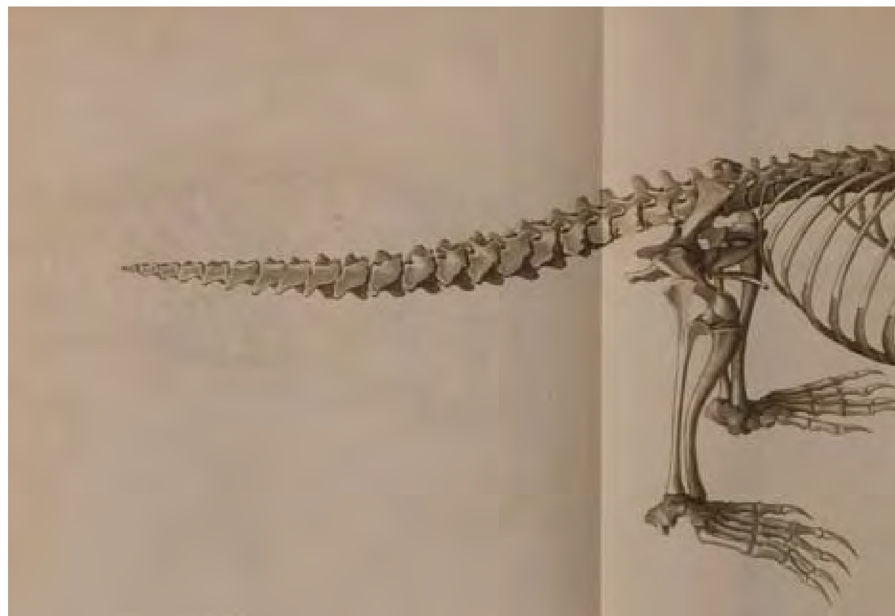
The College works hard to promote surgery as a career to both school and medical students. Over the past year we have organised 42 career events, workshops and presentations aimed at informing students of the skills and knowledge required to become a surgeon. We helped surgical trainees at a hospital in Bangor, North Wales, to organise a careers fair and skills day for local sixth-form students. Over the next year we will be supporting five other hospitals to organise surgical careers events.

We also produced guidance for surgical trainees outlining the career options in surgery and giving an overview of the nine surgical specialties. Our Women in Surgery (WinS) group provides advice, guidance and support for woman already in surgery or considering it as a profession. Our annual WinS conference, with Branwen Jeffreys, BBC Health Correspondent, as keynote speaker, attracted 220 delegates.

> I attended a College careers evening for girls interested in surgery when I was at school. It really inspired me to pursue a surgical career and I am now completing my medical degree at Manchester. I have recently been appointed to the College's Women in Surgery committee and am also very involved in my university surgical society. I am really grateful to the team at the Royal College of Surgeons for supporting me throughout my career to date.
>
> **Elspeth Hill, medical student**

Library and Information Services

The College library provides fellows, members, affiliates and examination candidates with learning resources to support their training, research, CPD and clinical practice. It has an unrivalled collection of historical and contemporary material focusing on surgical, dental and medical 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. The national importance of the library collections was recognised in 2008 by support from the Challenge Fund of research libraries, the British Library and the Research Information Network. This has enabled the entire College library catalogue to become part of Copac®, a freely available database comprised of the online catalogues of major UK research and national libraries.

With the support of a grant from the Wellcome Trust's Research Resources in Medical History scheme, we are cataloguing our printed monograph collection from 1800–1850. This collection of works covers all aspects of medicine such as human and comparative anatomy, physiology, histology and pathology, as well as disease, public health, dentistry and surgery. It also provides an important context for the archive and museum collections. The collection's physical condition is poor, underlining the importance of the library's Adopt a Book scheme, which is vital to ongoing conservation work.

In addition, further funding from the Wellcome Trust has enabled us to continue to catalogue the tracts and pamphlets. Approximately 28,000 of the 30,000 items have now become available through the library online catalogue and through Copac®.

The cataloguing projects, together with increased visibility via Copac®, have enabled us to uncover many unique and previously undiscovered items, and have raised

Plate showing the duck-billed platypus from Ludwig Markus Jaffé, *De ornithorhyncho paradoxo*, (published Berlin, 1823)

I've just looked at the paediatric anaesthesia section and I am impressed. It is very useful to have reference material in one accessible place. The Association of Paediatric Anaesthetists' guidelines on paediatric anaesthesia are useful to me in teaching situations for instant referral and retrieval. Day-to-day in-theatre teaching means that this material is available for quick reference.

David Fell, Consultant Anaesthetist, accessing *NHS Evidence – surgery, anaesthesia, perioperative and critical care*

Skeleton of a dog, from William Cheselden's *Osteographia (Or the Anatomy of the Bones)*, published 1733

awareness of the library collections among the research community and the public. This is evidenced by the fact that use of the online library catalogue increased by 27.3% compared with the previous year.

To support National Pathology Week, we held the *Fathers of Clinical Pathology* exhibition, which focused on medical innovators whose work emphasised pathological study, contributing to the eventual establishment of pathology as a specialty in the 20th century.

A collection of evidence-based guidance and practical resources is also freely available online via *NHS Evidence – surgery, anaesthesia, perioperative and critical care* (www.library.nhs.uk/theatres), formally a specialist library of the National Library for Health, which is managed by the College library in partnership with The Royal College of Anesthetists and University Hospitals of Morecambe Bay NHS Trust. The new critical care element of the website was launched on 1 June 2009. A total of 95,381 unique visitors used the site in 2008 compared to 57,580 in 2007.

Future plans

» We aim to make 90% of our journal holdings available online and develop an e-book collection, together with the necessary systems, so that we can provide a 21st-century digital library service.

- 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 develop and maintain *NHS Evidence – surgery, anaesthesia, perioperative and critical care* for the National Institute for Health and Clinical Excellence.

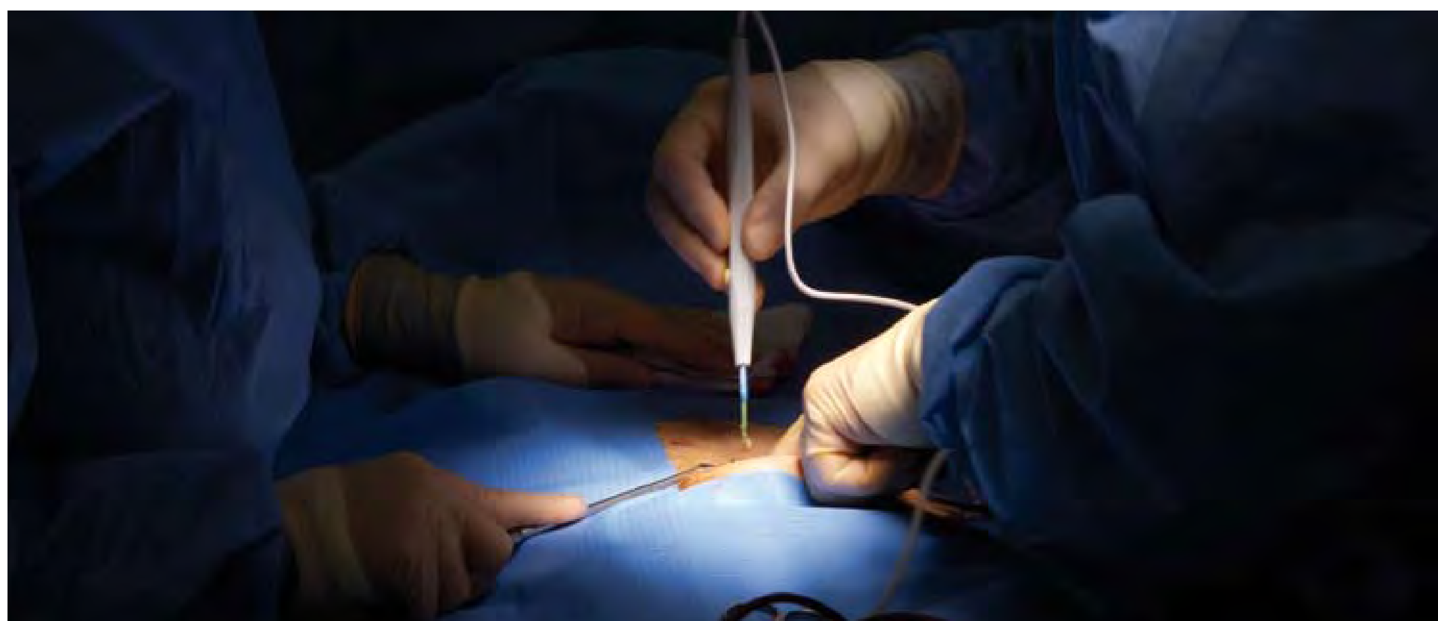
25 November 2009 marked the 125th anniversary of the first documented modern-day brain tumour surgery for a glioma, performed in London by Rickman John Godlee in 1884. The International Brain Tumour Alliance (IBTA) published a booklet commemorating this landmark operation. Copies were distributed worldwide to patients and neuro-oncology specialists.

As co-author with Denis Strangman, Chair of the IBTA, I researched this subject at the Royal College of Surgeons' wonderful library and archive collection, an important source of material and photographs relating to the Godlee story. As well as housing Godlee material and being a serene and inspirational place in which to work, the library's staff were extremely cordial, helpful and efficient.

Under the watchful eye of Sir Rickman's portrait, I carried out my research in the very same lofty and imposing room in which he might have also worked nearly 100 years ago. It was a very enjoyable and memorable experience.

Kathy Oliver, Co-Director of the IBTA

Pioneering Surgical Research and Techniques



Surgical research enables the development of procedures and techniques for the benefit of the patient.

Surgical research has continued to be a focus of the College's work. The College has a central role in supporting the surgical community to identify and highlight innovative practice and promote its evidence base and widespread adoption.

In March 2009 we invited key stakeholders to discuss the future of surgical research. Introducing the seminar, John Black, College President, stated that we would like to see an increase in investment and for all surgeons to be encouraged to engage in research. In 2007 only 1.4% of government spending on medical research was allocated to surgery.

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 2008 a total of 143 surgical trainees competed for 37 research fellowships.

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.

A magic bullet for biliary cancer

Siobhan McKay
Department of Surgery and Department of Histopathology; Division of Surgery, Oncology, Reproductive Biology and Anaesthesia; Imperial College London

Cholangiocarcinoma is cancer of the bile ducts, which carry bile from the liver to the gut. It is a devastating cancer, with the number of cases diagnosed per year almost equalling the number that die per year. The number of cases is rising. Surgery provides the only chance of a cure; chemotherapy has little or no effect. Four-fifths of people have too advanced disease at diagnosis to offer surgery. These people will only live for approximately six to nine months. It is hoped that a treatment can be developed that will effectively bring currently available or new therapies directly to cancer cells to kill them. This could then be used either following surgery to improve chances of cure or before surgery to reduce the size of the tumour and make it operable.

Genes and ear inflammation

Mahmood Bhutta
MRC Mammalian Genetics Unit, Harwell, Nuffield Department of Surgery, University of Oxford

Inflammation of the ear is very common in children and may manifest as an ear infection or as fluid in the ear, called 'glue ear'. Some children develop persistent or repeated problems with inflammation in their ears and may have grommets (little tubes) put into their ears. We do not understand why this inflammation happens but we know genes are important. This project will analyse the genes of children having grommets to find what may be causing the inflammation. If a gene is discovered it will help us understand, prevent and treat these diseases.

In addition to the fellowship scheme, the College makes travel grants available to selected trainees to allow them to visit centres abroad to learn and exchange ideas. We also provide pump-priming awards to new consultants, allowing them to continue to develop their academic interests. These and other initiatives rely very much on the generosity of our donors, to whom we are very grateful.

In July 2008 DH provided funding for a number of post-CCT fellowships throughout England. The eligibility criteria for these were restricted to trainees who have completed their training in England and gained their CCT within six months of the start date of the fellowship. The College was asked to administer the recruitment and we successfully appointed over 35 fellows to these posts. The first few appointed are reaching the end of their fellowships and we have received very positive feedback.

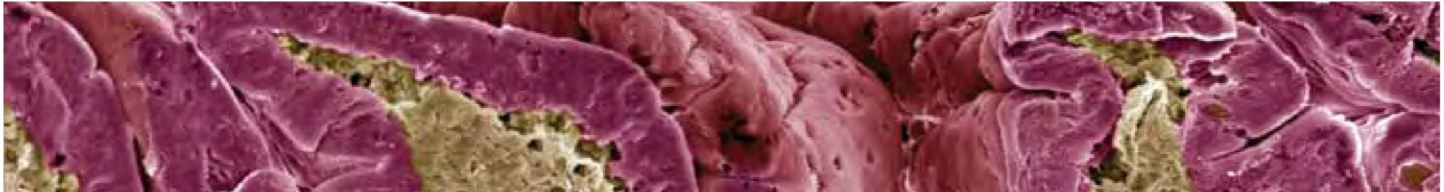
Organ donation specialists

In April 2009, in response to DH's Organ Donation Transplant Taskforce's recommendation on how to increase the number of organ donors in the UK, the College established 20 additional post-CCT transplant fellowships with the British Transplantation Society (BTS), supported by DH. The 20 specialists will be learning a range of the latest organ retrieval and

The post-CCT fellowship in laparoscopic donor nephrectomy (kidney transplantation) is proving to be very interesting. My time is split between the Royal Free Hospital and Guy's Hospital, as well as Great Ormond Street Hospital. In my first month I have been directly involved with 13 laparoscopic donor nephrectomy cases and by the end of the year I will have undertaken 60, which will comprise a mix of both hand-assisted and totally laparoscopic procedures. I will also work on renal transplantation, paediatric transplantation and complex vascular access.

The intensity of the operative exposure is high, as is the commitment of the trainers. I am able to focus selfishly on becoming a safe, independent, laparoscopic donor nephrectomy surgeon. I am confident that over the next 25 years both future patients and future trainees will benefit from the time invested in me during this year.

Ben Lindsey, Post-CCT Fellow, London



transplantation techniques from leading experts at units across the country. These new posts will help to meet the current skills gaps and will boost the national network of organ specialists in key centres across England.

The College has also offered grants of up to £10,000 for ten newly appointed consultants and senior lecturers in surgery who are working at hospitals and universities within the UK. The aim of the awards is to give assistance to such consultants in the early stages of their independent research careers.

Future plans

» We will award 25–30 research fellowships in 2009–2010.
» We will award 5–10 pump-priming grants to young consultant surgeons.
» We will support 9–12 medical students in the UK aiming to achieve an intercalated Bachelor of Science degree in surgery.
» With support from the Dunhill Medical Trust, we will offer five surgical research fellowships into diseases of ageing and surgical treatments for older people.

As part of my further training, I have taken up a joint College/BTS fellowship in laparoscopic donor nephrectomy. With the increasing demand on organ donation, it is important that we are able to offer minimally invasive techniques (keyhole surgery) of organ retrieval in order to minimise the impact of surgery on the live donor.

I am currently based at the Freeman Hospital, where I will be exposed to about thirty totally laparoscopic live donor procedures over the next six months, following which I will rotate to Manchester Royal Infirmary to learn the hand-assisted approach. I am grateful to the Royal College of Surgeons and BTS for giving me the opportunity to further my career before moving into a consultant post.

Lutz Hostert, Post-CCT Fellow, Freeman Hospital, Newcastle

While much of the debate on donation has focused on the complex issues surrounding presumed consent, what eventually matters is that more people on the transplant waiting list get quicker, more effective, life-saving transplants using the best techniques. We have to look at every way to improve donation rate and it is the duty of the Royal College of Surgeons to ensure the generosity and aspirations of donors are met by providing our surgeons with the skills to make every donation count.

John Black, College President, on transplantation

JOHN HUN
BORN
14TH FEBRUARY
DIED

The National College

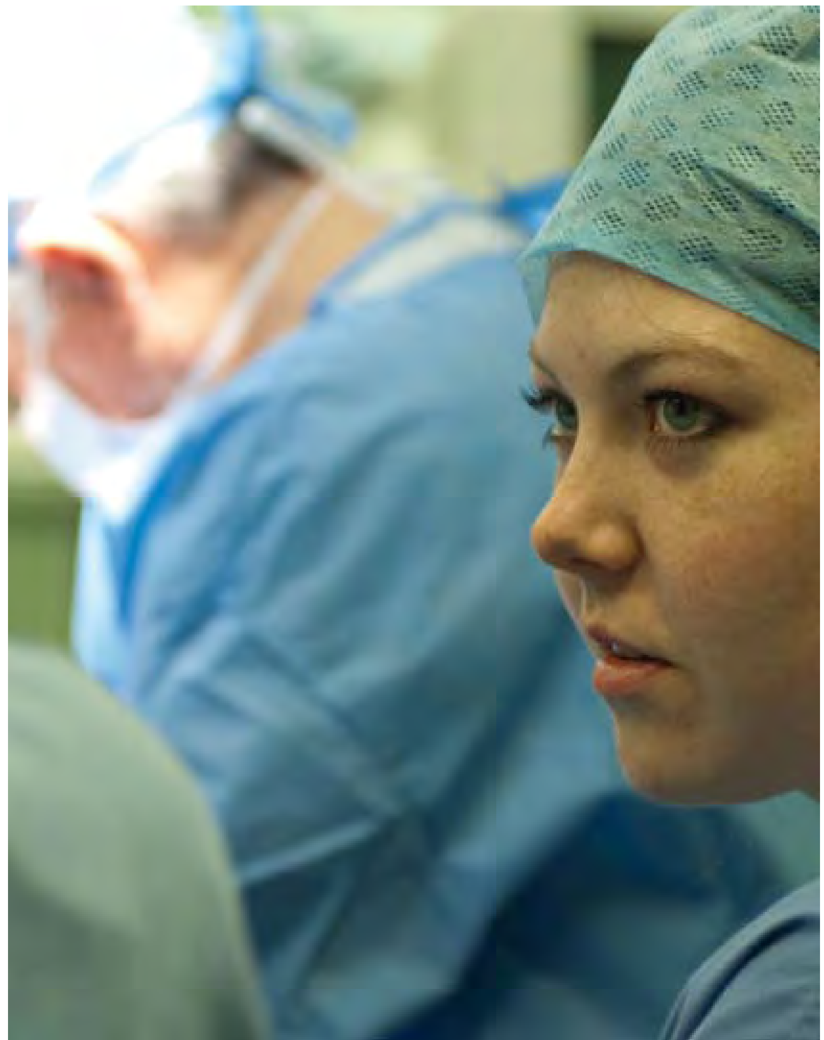
A focus of the College's work is providing advice and support to surgeons on professional issues and ensuring the delivery of training in the workplace to ensure the highest standards of patient care.

Supporting surgeons at work

We are currently piloting a new support service for surgeons at a local level to provide advice on professional and service issues. This structure is parallel to, but separate from, the schools of surgery, which deal with surgical training. It is envisaged that in each strategic health authority, and in Wales and Northern Ireland, there will be a director for professional affairs (DPA). In addition there will be nine regional specialty professional advisors (RSPAs), representing the specialty associations. The structure is a joint initiative between the College and specialty associations. The pilot has been expanded from two to seven regions.

Future plans

» We will develop an induction and training programme for DPAs and RSPAs.



The International College

By delivering courses abroad, in particular in developing countries, we are spreading best practice and improving the surgical skills of trainees and trainers.

The College plays a major role in delivering education programmes overseas and, in particular, in pioneering new methods of teaching. Exams are currently being run in Egypt, India, Sri Lanka and Lebanon, and potentially Iraq in 2010. We have introduced surgical skills training in over 70 centres overseas and more recently in Jordan, Yemen, Sudan, Dubai, Syria and Iran.

Our research methods course for surgeons was introduced in Malawi and surgeons from neighbouring countries are helping to train orthopaedic surgeons in knee arthroscopy and knee surgery.

The College offers awards for clinical students at a UK medical school wishing to pursue a career in surgery to undertake their elective attachment in a surgical field in the developing world. This is known as the Preiskel Elective Prize in Surgery and in 2008 eight awards were given to medical students, who carried out their electives in India, Ethiopia, Cambodia, Nepal, Samoa and Hungary.

Future plans

- We will run a surgical skills course in Laos and a research methods course in Tanzania.
- We will continue to offer awards to medical students wishing to pursue a career in surgery to enable them to do their elective attachment in a surgical field in the developing world.

Management of fracture malunion in the developing world

Jubin Joseph
University of Oxford, recipient of the Preiskel Elective Prize in Surgery

My medical elective, as part of my final year of medical school, was spent mostly in Cambodia working in the Children's Surgical Centre (CSC) in Pnomh Penh. Under the guidance of Dr Jim Gollogly, the CSC provides a wide range of surgery, encompassing facial reconstruction, orthopaedic surgery, eye surgery, and plastic and burn surgery, through which it aims to improve the quality of life for Cambodians. Integral to this mission is a programme of training local surgeons and health workers, focusing on the development of sustainable health services.

During my time there, I assisted in theatres during cleft lip and palate repairs, cataract surgery and predominantly orthopaedic surgery. This encompassed the revision of painful or disabling amputation stumps from landmine injury and the removal of shrapnel, bullets and other foreign bodies but concentrated on the correction of fracture malunion. It was the correction of these fractures that I audited, comparing current practice to the evidence available, and I presented my findings in a seminar of local surgeons from the district. This process involved educating local surgeons about the process of audit and clinical governance to improve local practice and proved very rewarding.

My elective offered me fantastic insight into the practical realities of surgery in a resource-limited setting, combined with an exposure to a variety of surgical presentations and techniques uncommon at home.

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 Hunterian Museum attracted 45,260 visitors in 2008–2009 with 90% rating the experience as 'excellent'. 102 volunteers, including over 60 surgeons or surgical trainees, supported museum staff by providing front-of-house services including tours and talks for visitors, assisting with events or helping with the care of collections.

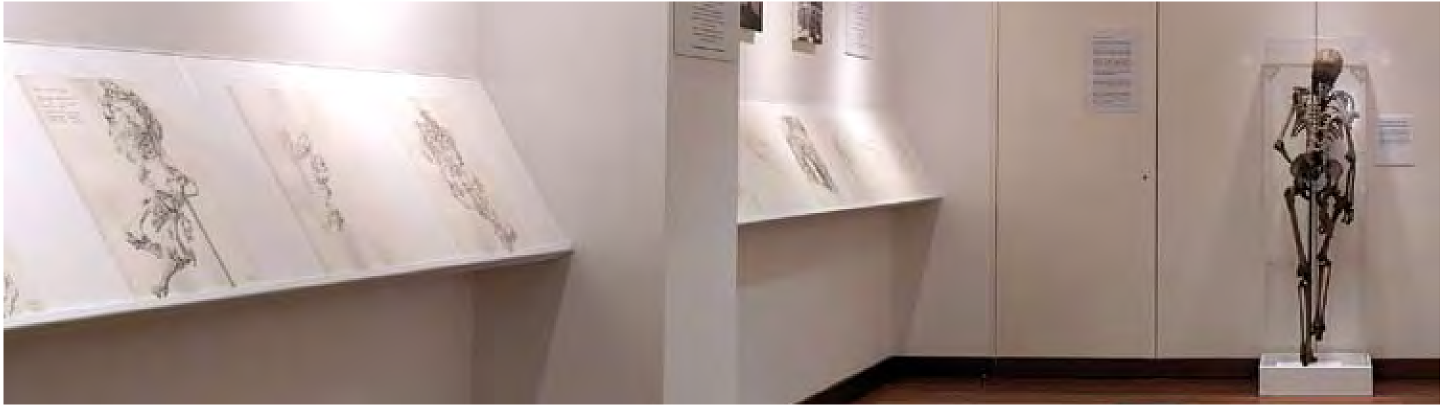
In autumn 2008, the museum staged an exhibition by artist Lucy Lyons focusing on the disease *Fibrodysplasia ossificans progressiva* (FOP), in which muscle turns to bone. The exhibition contained drawings made from skeletons in the museum collection as well as studies of and quotes from patients living with FOP. This exhibition aimed to raise awareness of FOP and to encourage further research, and it coincided with an international symposium on FOP held at the College.

With funding from the Newman Foundation, a museum audio tour was introduced for visitors in February 2009. During the year, 279 public events were delivered, comprising 58 facilitated school visits, 16 family workshops and 13 public talks, including a study day on 'Darwin in London'. 2,581 school students visited the museum during the year. There were 10 'Medicine through Time' workshops for history GCSE students, which explored the role of surgeons in medical history.

I visited the Hunterian Museum at the beginning of 2009 to view the odontological collection, in particular the collection of human perinatal teeth to develop an atlas of tooth development and eruption. This consists of 56 post mortem dentitions from 28 weeks' gestation to one year of life, with age of gestation recorded and other details, which is unique to this collection. This enabled me to construct early dental development diagrams from 28 weeks in utero to 3 months after birth, filling an important gap in knowledge.

This would not have been possible without the valuable support of the museum's staff, who provided access to the collection. I would recommend any researcher to visit and use the collections in the Hunterian Museum. The curation is excellent and the staff are extremely helpful and supportive.

Sakher AlQahtani, PhD student, Queen Mary, University of London



We enjoyed our visit to the Hunterian Museum enormously and are hoping to bring another group next autumn, when we can spend more time with you and take advantage of the guided tour. All of us were very impressed with the museum: the stunning way the items are displayed, the interactive sections (very popular with our would-be surgeons) and the helpful and interesting staff. It was also quite a coincidence to see a television programme shortly after our return, in which Ian Rankin visited the museum. Once again, thank you very much. We look forward to our return visit.

Tim Garland, Head of Humanities, Cape Cornwall School

Changing displays of artworks were staged in other areas of the College. Works by Susan Aldworth, based on her collaboration with doctors, neuroscientists and artists, were displayed in the foyer of the new surgical skills area at the College and drawings of plastic surgery by the artist Dickie Orpen were exhibited outside the lecture theatres on the ground floor. The College participated in the London Open House weekend in autumn 2008, which provided an opportunity for visitors to view the art and architecture in areas of the College not normally open to the public.

Acquisitions included portraits of six women surgeons, commissioned from the fine art photographer Jane Brettle. Her subjects were individuals who have made a substantial contribution to surgery and to the work of the College, including Miss Phyllis George, the first woman elected to the College Council. During the year, work also began on an ambitious project to re-catalogue the College's dental collections, with the support of the Faculty of Dental Surgery and a bequest from the late Professor AEW Miles. The project will make the collection accessible for research and teaching, encouraging its use by dental surgeons and trainees.

Future plans

- We will maintain visitor numbers at 44,000 per annum.
- We will complete a museum guidebook.
- We will deliver 20 schools events.

The Dental Faculties

The dental faculties 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 800 candidates took this exam during 2008–2009. The diploma in orthodontic therapy for dental care professionals continued to run in Leeds and commenced in South Wales. The Faculty continued to administer dental specialty membership examinations and introduced a new oral surgery intercollegiate fellowship examination.

In March 2008 the Fellowship in Dental Surgery by assessment of The Royal College of Surgeons of England was introduced for dental surgeons who have had more than five years of continuous good standing in dental surgery, have a membership diploma recognised by the Faculty and have demonstrated commitment to the highest clinical standards and excellence in all aspects of their work. The first awards will take place in 2010.

The FDS, in collaboration with the Faculty of General Dental Practice (UK) (FGDP(UK)), DH and other medical royal colleges, successfully launched an e-learning project for postgraduates that will encompass the UK dental foundation curriculum and provide education 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 was awarded the contract to administer this programme.

The 2009 FDS research award went to Dr Jon Higham for his research into the links between periodontal and cardiovascular disease.

Future plans

- A new joint FDS–Wellcome Trust research fellowship in dental surgery will be offered in 2010.
- We will continue to refine the Overseas Registration Examination part 2 for the General Dental Council (GDC).
- We will continue orthodontic therapy courses in Leeds and South Wales and offer additional courses in Newcastle and London.

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.

It is carrying out a two-year national 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. The project is looking at the national incidence of osteonecrosis of the jaw in patients receiving bisphosphonates, used to treat osteoporosis and similar diseases. A large proportion of cases with osteonecrosis of the jaw occur among cancer patients receiving high-dose intravenous bisphosphonates.

The FGDP(UK) has updated its clinical examination and record-keeping guidance, advising and informing clinicians on the practical and legal aspects of record keeping, while complying with clinical governance. It also set out new guidance for standards in leadership and management in dental health.

The first orthodontic therapists registered with the GDC after completing the new Diploma in Orthodontic Therapy, awarded by the FGDP(UK) and FDS. Orthodontic therapists deliver a range of treatments including placing and adjusting fixed appliances, inserting active removable orthodontic appliances adjusted by a dentist and removing fixed appliances, orthodontic adhesives and cement.

The FGDP(UK) has also announced the launch of a route to the Diploma of Fellowship of the Faculty of General Dental Practice (UK) by non-clinical assessment. The assessment, previously only available to those currently working in primary dental care, has been developed to mark the achievements of those not currently practising (and so ineligible to be assessed via the normal clinical route) who have made an exceptional commitment and contribution to primary care dentistry.

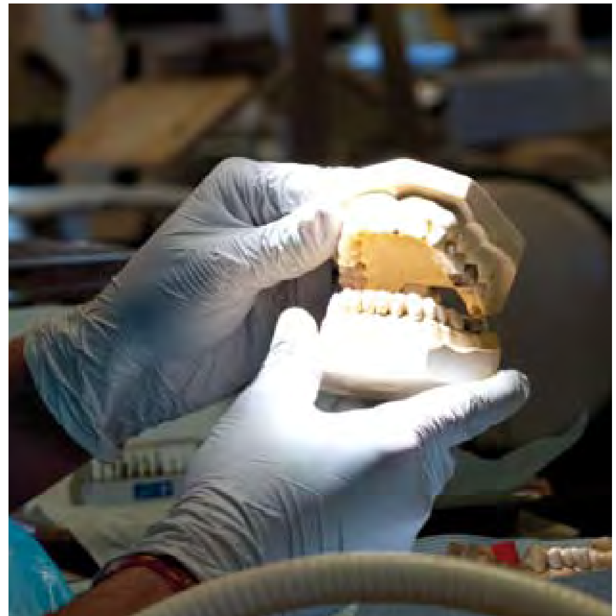
e-Den, the national e-learning initiative encompassing dentistry's foundation years' curriculum, had its pilot phase during the year. This project is a collaboration between the four dental faculties of the surgical royal colleges and DH. It will be available nationwide and free of charge to all NHS trainees and all relevant staff with an NHS contract, and will offer educational support for the two years after graduation.

Future plans

- We will promote participation on the Career Pathway (including non-clinical fellowships).
- We will promote and undertake research in primary dental care and put in place systems for the collection and analysis of outcome data to help dentists to improve patient care.
- We will develop the Lay Advisory Group and ensure that the patient view is incorporated in all matters relating to the Faculty's activities.
- We will plan a course in minor oral surgery.

As I am a cancer survivor, Myeloma UK asked if I would like to help with the BRONJ research activity. BRONJ is a concern to myeloma patients and so this information gathering and analysis is a great step to fill a knowledge gap to help quantify and address the side effects of myeloma and other cancer treatments. I am pleased to help by giving a patient's perspective.

Malcolm Lane, myeloma patient



Funding Partnerships

As a registered charity (no 212808) the College relies upon charitable support to underpin its work in advancing surgical standards through education, research and training.

The College is grateful to its 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
- Band Trust
- Barbara Whatmore Charitable Trust
- Bedell Trust
- Bernard Sunley Charitable Foundation
- Brinsley Ford Charitable Trust
- British Association of Plastic, Reconstructive and Aesthetic Surgeons
- Caravan Club (Suffolk Centre)
- Enid Linder Foundation
- Family Rich Charities Trust
- Fitton Trust
- Frances and Augustus Newman Foundation
- GD Herbert Charitable Trust
- GM Morrison Charitable Trust
- George and Esme Pollitzer Charitable Settlement
- George Drexler Foundation
- Gilbert and Eileen Edgar Foundation
- Golden Bottle Trust
- Grand Lodge of Freemasons 250th Anniversary Fund
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- Henry Lumley Charitable Trust
- Hospital Saturday Fund
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- Joseph Strong Frazer Trust
- Laurence Misener Charitable Trust
- Limbless Association
- Michael and Anna Wix Charitable Trust
- Oakdale Trust
- Peacock Charitable Trust
- Roger Vere 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
- Tony Metherell Charitable Trust
- Vascular Surgical Society of Great Britain and Ireland
- WD Macpherson Charitable Trust
- Wellcome Trust
- Wesleyan Charitable Trust
- Wyndham Charitable Trust
- Wolfson Foundation
- Worshipful Company of Barbers
- Worshipful Company of Needlemakers

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- Biomet UK Ltd
- BMI Healthcare
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- CareFusion
- Carl Zeiss Ltd
- Codman Ltd
- Conmed Linvatec UK Ltd
- Danone Baby Nutrition
- DePuy Spine
- Ethicon Endo-Surgery UK
- Ethicon UK
- Ethicon Women's Health and Urology
- Forth Medical Ltd
- HCA International
- Karl Storz Endoscopy (UK)
- Limbs & Things Ltd
- Medacta UK Ltd
- Medartis Ltd
- Medtronic Ltd
- Mentor Medical Systems Ltd
- Mölnlycke Health Care Ltd
- Novartis Pharmaceuticals UK Ltd
- NuVasive UK Ltd
- Nycomed UK Ltd
- Olympus Medical
- Roche Products Ltd
- Scient'x UK Ltd
- Smith and Nephew UK Ltd
- Stryker UK
- SurgiC
- Synthes Ltd
- Thomas Tunnock Ltd
- WL Gore and Associates UK Ltd
- Zimmer 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
- Peter and Nora Locan Fund
- Margaret Witt Scholarship Fund
- Norman Capener Fund
- Osman Hill Collection and Research
- Parks Visitorship
- Philip and Lydia Cutner Fund
- Preiskel Family Fund
- Shortland Legacy
- Simpson Legacy
- Vandervell Research Fund

Legacies

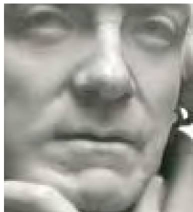
- The late Miss JEV Baker for the Eagle Project
- The late Mr SJ Baker for general charitable purposes
- The late Mr RD Barnes for general charitable purposes
- The late Mr GG Bisley for general charitable purposes
- The late Mrs JB Black for general charitable purposes
- The late Mrs TH Clarke for surgical research
- The late Miss MC Colledge for the Colledge Family Memorial Fellowship Fund
- The late Miss DK Cooke for general charitable purposes
- The late Miss JR Cox for surgical research
- The late Ms KP Curtis for general charitable purposes
- The late Mr GGT Fletcher for surgical research
- The late Miss BM Godin for the education orthopaedic portfolio
- The late Mr M Goldman for general charitable purposes
- The late Mr AR Graham for general charitable purposes
- The late Ms M Guyatt for Sir Alan Parks Research Fellowship Fund
- The late Mrs FF Kerr for the Library and Hunterian Museum
- The late Mr PDA Lee for general charitable purposes
- The late Ms VCM London for general charitable purposes
- The late Mr REW Lumley for general charitable purposes
- The late Miss BM Mackenzie for general charitable purposes
- The late Prof AEW Miles for the Faculty of Dental Surgery
- The late Ms VP Newall for general charitable purposes
- The late Mr RW Rowe for general charitable purposes
- The late Miss LF Suche for general charitable purposes
- The late Mr I Sutherland for general charitable purposes
- The late Miss FE Tiffany for general charitable purposes
- The late Ms EM Wall for general charitable purposes
- The late Dr MJ Witt for the Margaret Witt Scholarship Fund

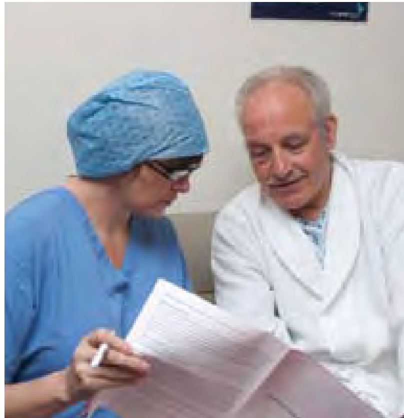
Abbreviations

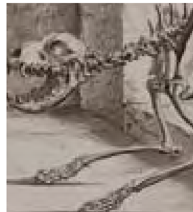
AoMRC	Academy of Medical Royal Colleges
ATLS®	*Advanced Trauma Life Support®*
BRONJ	bisphosphonate-related osteonecrosis of the jaw
BTS	British Transplantation Society
CCT	Certificate of Completion of Training
CEU	Clinical Effectiveness Unit
CPD	continuing professional development
CRANE	Craniofacial Anomalies Network
CCrISP®	*Care of the Critically Ill Surgical Patient®*
DH	Department of Health
DPA	Director for Professional Affairs
EWTD	European Working Time Directive*
EWTR	European Working Time Regulations*
FDS	Faculty of Dental Surgeons
FGDP(UK)	Faculty of General Dental Practice (UK)
GDC	General Dental Council
GMC	General Medical Council
IBTA	International Brain Tumour Alliance
ISCP	Intercollegiate Surgical Curriculum Programme
IRM	Invited Review Mechanism
JCST	Joint Committee on Surgical Training
MJDF	Membership of the Joint Dental Faculties
MRCS	Membership of the Royal College of Surgeons
NRLS	National Reporting and Learning Service

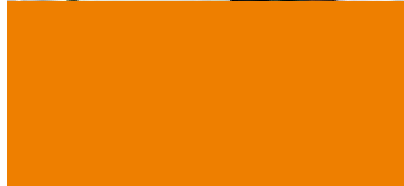
OSCE	objective structured clinical examination
PLG	Patient Liaison Group
PMETB	Postgraduate Medical Education and Training Board
PROMs	patient-reported outcome measures
RSPA	regional specialty professional advisor
SAC	specialist advisory committee
SAS	staff grade and associate specialist
TAIP	*Training and Assessment in Practice*
TtT	*Training the Trainers*
WHO	World Health Organization
WinS	Women in Surgery

*The European Working Time Directive (EWTD) is the European law that limits the number of hours that doctors are allowed to work over an average week. The final stage of implementation of the directive was in August 2009 after which point the directive became the European Working Time Regulations (EWTR).









Trustees' Report and Financial Statements

2008–2009

Trustees' Report

for the year ended 24 June 2009

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 2009 were:

Mr J Black
President

Mr W Thomas and Mrs L de Cossart
Vice-Presidents

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

In July 2009 Mr J Black was re-elected as President and Mr W Thomas was re-elected as Vice-President. Mr R Collins was elected as the second Vice-President. Mr J Shepherd and Miss C Marx were admitted to the Council. Mrs L de Cossart and Professor B Avery were demitted.

The principal officers employed by the College were:

Chief Executive	Mr D Munn / Mr A Bennett (from 5 January 2009)
Advisor to the President	Mr C Duncan

Communications	Dr A Cook
Professional Standards and Regulation	Mrs K Smith
Education	Ms F Alexander (acting) / Mr M Larvin (from 1 December 2008)
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

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

Solicitors

Bircham Dyson Bell	50 Broadway, London SW1H 0BL
Eversheds	1 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 on a divisional structure to suit the developing activities of the College. The chief executive is responsible for the overall management of the College and delegates management of specific functions to division officers, each of whom is head of the department supporting the division and works under the direction of the responsible member of Council. Division functions, their role and Council members involved during the year were as follows:

Division	Role	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 R Collins
	Accommodation, facilities, staff policies and procedures, and health and safety	Mr R Collins
	Information Systems	Professor J Stanley
	Library and Information Services	Mr J Getty
	Museums and special collections	Mr D Jones
Professional Affairs	Overall divisional responsibility	Mrs L de Cossart
	Professional standards	Professor I Taylor
	Regional policy – training	Mrs L de Cossart
	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 Faculties and Presidential	Overall divisional responsibility	Mr W Thomas
	PR and communications	Mr W Thomas
	Policy	Professor A Mundy
	Publications	Mr W Thomas / Professor I Taylor
	Patient Liaison Group	Mr R Greatorex
	Faculty of Dental Surgery	Professor D Willmot
	Faculty of General Dental Practice (UK)	Mr R Hayward

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:

		2008–09	2007–08	2006–07	2005–06
Surgeons	UK	8,048	8,376	7,969	7,615
	Overseas	1,829	1,799	1,477	1,375
Faculty of Dental Surgery	UK	2,547	2,604	2,472	2,372
	Overseas	404	478	415	377
		12,828	**13,257**	**12,333**	**11,739**
Faculty of General Dental Practice (UK)		**4,780**	**3,890**	**3,392**	**3,347**

Objects 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 the 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 its 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 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 College 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 and have approximately 17,000 members, providing strong leadership and support for surgeons in all matters relating to their surgical practice, throughout their 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. This is achieved through our work 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, our publications and our journals, 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 2008–2009.

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 aim. Some examples are listed below but more details can be found in the *Annual Report*.

The College continued to support surgical training by maintaining the Intercollegiate Surgical Curriculum Programme (ISCP), a system that defines the standards of progression and incorporates assessments of competence for trainees in specialist training. During the year 3,565 trainees registered on the ISCP with a given level of training such as specialty training year 3. The majority of validated trainees (84%) have set a 'learning agreement', which is a written statement of the mutually agreed learning goals and strategies negotiated between the trainee and his or her assigned educational supervisor. The College commenced the review and update of the specialty syllabuses.

The College continued to support the development of revalidation processes for surgeons. Working with the specialty associations we developed standards and through the Supporting Surgeons in the Workplace Programme (SSWP) piloted and further continued the implementation of a new regional professional affairs network that will support surgeons locally. The College undertook development of an online portfolio that will help surgeons collect the supporting information they will need for their revalidation. A vital part of revalidation is continuing professional development (CPD). The College maintained its support of CPD by providing learning resources including courses and library resources. The College also began the development of a CPD accreditation service that will accredit CPD activities and provide a marker of quality for surgeons when they are choosing between providers.

The College supported surgical research through a range of activities including its flagship surgical research fellowship scheme. Surgical techniques that are improved through research can offer better survival rates and quality of life for patients than might otherwise be achieved through non-surgical treatment. Surgical research is unique in its single-minded search for solutions to a specific disease or problem that has been identified by practising surgeons who treat patients every day. The College secured government funding of £1.2

million to run the post-Certificate of Completion of [Surgical] Training (CCT) transplant research fellowships. A CCT is awarded by the Postgraduate Medical Education and Training Board (PMETB), on our recommendation, when a trainee passes the Fellowship of the Royal College of Surgeons (FRCS), which is a professional qualification, and successfully completes his or her training.

The Education Department continued to promote and support the professional development of surgeons at every stage in their careers. We delivered 760 core courses at international and regional centres; additional radiography teaching materials were developed to support the core surgical anatomy programme; and 73 specialty courses were delivered.

The College completed Phase 2 of the Eagle Project, a three-stage refurbishment project that will transform our education facilities into a national centre of excellence for surgical education, training and assessment by 2010. Phase 2 comprised the clinical skills unit, which was opened by The Princess Royal on 18 March 2009. It houses state-of-the-art technology that will revolutionise training for surgical professionals, such as theatre nurses, surgical care practitioners and radiologists. As well as incorporating simulation facilities, the College envisages the unit will make use of virtual reality training, which will provide trainees in remote sites with access to learning via the internet.

Future plans

In 2009–2010, the College intends to have the ISCP content approved by the PMETB. With regards to the revalidation process, the College intends to have six SSWP pilots in place and evaluated and to have the online portfolio launched nationally. The College will continue to run its surgical research fellowship scheme as well as commence awarding post-CCT research fellowships. The Education Department will continue to deliver and develop courses at all levels. By June 2010 the College intends to deliver 750 core courses at international and regional centres, a minimum of 60 courses across a range of specialties and 98 CPD courses. The College will complete Phase 3 of the Eagle Project, the seminar suite, which will link the technical teaching areas with breakout and seminar space, thereby greatly increasing the overall usability and versatility of the whole facility.

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 66 and 68).

The aggregate surplus of £0.4 million as shown on the *Consolidated Statement of Financial Activities*, before investment losses, consists of a deficit of £1.3 million on unrestricted funds, a surplus of £1.6 million on restricted funds and a surplus of £0.1 million on endowed funds.

The deficit on unrestricted funds was due to a combination of factors. There was a decrease in investment income coupled with an increase in courses and subscriptions income; however, the cost of running charitable areas of activity also increased, particularly in education and course provision. The operational deficit includes planned spend on new and ongoing project initiatives.

The surplus on restricted funds of £1.6 million (before transfers) comprises a net increase in grants held of £2.2 million and a decrease of £0.6 million in trust fund balances used for funding educational, research and museum project developments. The increase in grants comprises the net increase of £0.8 million for the Eagle Project, the

post-CCT research fellowships grant of £1.2 million and a net increase in other grants of £0.2 million. The decrease of £0.6 million in trust fund balances is due to more research fellowships being funded from trusts.

Endowed funds increased by £0.1 million (before transfers) due to a new legacy of £0.2 million coupled with a reduction of £0.1 million of investment portfolio management fees charged against the capital value of the fund.

When the aggregate surplus of £0.4 million in the *Consolidated Statement of Financial Activities* is amalgamated with the decrease of £11.9 million in the capital value of the College's investment portfolio and a surplus on the sale of an investment property of £0.1 million, an overall decrease in net worth of £11.4 million is the outcome for the year. The capital value of the College's investment portfolio has been affected adversely by current economic conditions.

Income

Overall income of £27.2 million (2008: £26.5 million) was 3% or £0.7 million higher than the previous year. Under the Statement of Recommended Practice (SORP) 2005, income is required to be reported under three categories: *Incoming resources from generated funds* of £11.4 million (2008: £12.5 million), *Incoming resources from charitable activities* of £15.4 million (2008: £14.0 million) and *Other incoming resources* of £0.4 million (2008: £nil).

- The value of donations and gifts received was slightly lower than in 2008, mostly in restricted funds. This is mainly due to donations received for the Eagle Project being lower. These have to be recognised as income while the expenditure that they have funded is capitalised in fixed assets. Depreciation is charged against the restricted fund as each phase of the Eagle Project is completed.
- Legacies are unpredictable and were lower than in the previous year.
- Grant income decreased marginally.
- Residential and conference income has remained stable due to the continuing success of an effective marketing strategy of College facilities.
- Investment income levels were lower than in the previous year for unrestricted and restricted funds due to some one-off dividend payouts in the previous year.
- Course income has increased significantly due to a higher number of courses being organised in the Education Department and dental faculties as well as a new trainee fee for ISCP usage.
- Examination income increased marginally due to increases in the dental faculties' examinations being greater than decreases in surgical examinations.
- Subscription income shows an increase due to an increase in the level of subscription in all areas and an increased number of Faculty of General Dental Practice (UK) subscribers, despite a decrease in the number of surgeon members.
- Rents, charges and sales income has decreased slightly due to lower VAT recovery income and intercollegiate charges.
- Other income relates to the surplus on sale of a property owned by the College, the proceeds of which were designated to the Eagle Project.

Expenditure

Operational expenditure of £26.8 million (2008: £25.6 million) was incurred during the year on all activities and reflected a 5% or £1.2 million increase on the previous year. Under SORP 2005, expenditure is required to be reported under three categories: *Cost of generating funds* of £3.1 million (2008: £3.0 million), *Charitable expenditure* of £23.0 million (2008: £21.9 million) and *Governance* of £0.7 million (2008: £0.7 million).

The *Cost of generating funds* category has increased marginally.

Charitable expenditure includes the majority of categories:

- The level of education and course expenditure was higher than the previous year due to a greater number of courses being delivered, particularly in the Faculty of General Dental Practice (UK).
- Expenditure on standards, regulation and examinations has increased due to the higher costs of running examinations.
- The level of research expenditure was lower than in the previous year due to shorter-term grants being awarded.
- Clinical Effectiveness Unit and other funded-project expenditure has increased slightly due to an increase in project activity.
- Expenditure on museum and library services has increased due to expanded funded activity and also due to a feasibility study for the refurbishment of this area being carried out.
- Expenditure on communications and publishing has increased marginally due to the development of the communications function.
- Other professional activities have increased due to expansion in the Faculty of Dental Surgery.

Governance costs have remained static.

Total capital expenditure for the year was £2.5 million, of which £0.6 million has been spent in selectively improving general facilities, while capital expenditure of £1.7 million has been incurred on the Eagle Project and £0.2 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 upon 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 £0.2 million was achieved in 2009 (2008: £0.2 million) as business remained static. Its activities are consolidated in these financial statements (see note 10).

Investment policy and performance

The chaotic downturn of world markets has resulted in losses of £6.0 million in unrestricted funds with the portfolio being valued at £19.9 million at year end. The restricted and endowed funds portfolios were valued at £27.1 million at year end and have suffered losses in the year of £5.8 million.

The general funds investment objective is to maximise total returns after generating income of £0.9 million. The common investment fund and other funds investment strategy is to provide income of £1.25 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 and exceeded for 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 6–9 months of unrestricted operational expenditure. The College's reserves policy is that the *capital designated fund* should not fall below 6 months of unrestricted operational expenditure. The balance of the College's designated funds is represented by tangible fixed assets, which 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 decrease in resources during the year was approximately £11.4 million, which when amalgamated with existing funds results in a net worth of £62.9 million. Of this, £23.0 million represents endowed funds' assets, where only the income, not the capital, can be spent on purposes specified by the donors, while a further £14.2 million is restricted in how it can be used as it consists of project grants and trust balances.

The unrestricted funds of £25.7 million includes designated funds of £7.5 million equating to the fixed assets used by the College in its activities; a *capital designated fund* of £14.0 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 £4.2 million.

The *Consolidated Balance Sheet* (page 68) outlines the main asset and liability categories aggregating to the net worth of the College, while the *Consolidated Cashflow Statement* (page 70) tabulates the impact of operating and investment activities on cash and bank resources.

The College's financial position has suffered this year due in the most part to the turbulent economic environment, which it cannot control. There is some uncertainty in the short to medium term. It is therefore imperative that professional and prudent management of controllable resources continues so that the College can 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 has been strengthened by the creation of a 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 (awards travelling fellowships to surgeons). Their financial statements are audited by Horwath 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 2008, the value of the Sir Ratanji Dalal Research Scholarship Fund endowed fund was £0.6 million (2007: £0.7 million) and its unrestricted fund was £0.06 million (2007: £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 2009, the value of the Colledge Family Memorial Fellowship endowed fund was £1.5 million (2008: £0.3 million) and its unrestricted fund was £0.02 million (2008: £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.

Trustees' responsibilities

The law applicable to charities in England and Wales requires the trustees to prepare financial statements for each financial year in accordance with the United Kingdom Generally Accepted Accounting Practice (UK GAAP) that give a true and fair view of the financial activities of the charity and the group during the year and of their financial position at the end of the year. In preparing financial statements giving a true and fair view, the trustees should follow best practice and:

- select the most suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity and the group will continue in operation.

The trustees are responsible for maintaining proper accounting records that disclose with reasonable accuracy the financial position of the College and the group and that enable them to ensure that the financial statements comply with the Charities Act 1993, the Charity (Accounts and Reports) Regulations and the provisions of the royal charter. They are also responsible for safeguarding the assets of the College 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

12 November 2009

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 2009, which comprise 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 auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the 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 UK GAAP 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 the trustees' report and consider the implications for our report if we become aware of any apparent misstatements within it. Our responsibilities do not extend to any further 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 judgements 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 that 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 UK GAAP of the state of the group and the parent charity's affairs as at 24 June 2009 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.

Horwath Clark Whitehill LLP
Chartered Accountants and Statutory Auditor
London

16 November 2009

Consolidated Statement of Financial Activities

for the year ended 24 June 2009

	Notes	Unrestricted funds £000s	Restricted funds £000s	Endowed funds £000s	Totals 2009 £000s	Totals 2008 £000s
Incoming resources						
Incoming resources from generated funds:						
Voluntary income:						
Donations and gifts		41	2,927	-	2,968	3,245
Legacies		573	80	182	835	938
Grants		-	2,320	-	2,320	2,453
Activities for generating funds:						
Residential, conference and other		2,837	-	-	2,837	2,836
Investment income		1,211	1,224	-	2,435	3,051
Incoming resources from charitable activities:						
Courses		5,466	413	-	5,879	4,583
Examinations		3,186	-	-	3,186	3,113
Subscriptions		4,027	-	-	4,027	3,636
Rents, charges, sales		980	1,366	-	2,346	2,651
Other incoming resources:						
Surplus on sale of property		354	-	-	354	-
Total incoming resources		18,675	8,330	182	27,187	26,506

	Note					
Resources expended	2					
Cost of generating funds:						
Fundraising costs for raising voluntary income		325	-	-	325	318
Investment management fees		38	91	87	216	272
Residential, conference and other trading costs		2,572	-	-	2,572	2,471
		2,935	**91**	**87**	**3,113**	**3,061**
Charitable expenditure						
Education and courses		5,836	1,168	-	7,004	6,500
Standards, regulation and examinations		5,177	1,549	-	6,726	6,371
Research grants	3	29	1,808	-	1,837	2,214
Clinical Effectiveness Unit and other projects		149	1,369	-	1,518	1,419
Museums and library		1,502	631	-	2,133	1,885
Communications and publications		1,612	50	-	1,662	1,524
Other professional activities		2,006	121	-	2,127	2,008
		16,311	**6,696**	**-**	**23,007**	**21,921**
Governance		693	-	-	693	677
Total resources expended		19,939	6,787	87	26,813	25,659
Changes in resources before transfers		(1,264)	1,543	95	374	847
Transfer between endowed and restricted funds	11	-	301	(301)	-	-
Changes in resources before other recognised gains and losses		(1,264)	1,844	(206)	374	847
Net loss on investments	10	(5,983)	(287)	(5,616)	(11,886)	(5,760)
Surplus on sale of investment property		-	-	69	69	-
Net movement in resources in the year		(7,247)	1,557	(5,753)	(11,443)	(4,913)
Brought forward 25 June 2008		32,941	12,605	28,756	74,302	79,215
Balance carried forward 24 June 2009		25,694	14,162	23,003	62,859	74,302

All activities are continuing activities. The notes to the financial statements are on pages 72 to 84.

Consolidated Balance Sheet

as at 24 June 2009

	Notes	Unrestricted funds £000s	Restricted funds £000s	Endowed funds £000s	Totals 2009 £000s	Totals 2008 £000s
Fixed assets						
Tangible fixed assets	5	7,483	6,858	-	14,341	13,366
Investments	10	19,913	4,373	22,722	47,008	57,720
		27,396	**11,231**	**22,722**	**61,349**	**71,086**
Current assets						
Stock		154	-	-	154	110
Short-term investments	10	-	-	-	-	1,700
Debtors	6	3,412	263	-	3,675	3,464
Cash and short-term deposits	7	3,374	2,668	281	6,323	6,365
		6,940	**2,931**	**281**	**10,152**	**11,639**
Current liabilities						
Creditors: amounts falling due within one year	8	(8,452)	-	-	(8,452)	(7,663)
Net current (liabilities) / assets		(1,512)	2,931	281	1,700	3,976
Long-term liabilities						
Creditors: amounts falling due after more than one year	8	(190)	-	-	(190)	(760)
Net assets		25,694	14,162	23,003	62,859	74,302

Funds						
Permanent endowment and other restricted funds	11	-	14,162	23,003	37,165	41,361
Unrestricted funds:	12					
Designated funds		21,484	-	-	21,484	29,013
Working reserves		4,210	-	-	4,210	3,928
		25,694	**14,162**	**23,003**	**62,859**	**74,302**

The notes on pages 72 to 84 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 £205,000 (2008: £203,000).

Approved on behalf of the elected members of Council and authorised for issue on 12 November 2009.

Mr J Black
President

Professor A Narula
Treasurer

Consolidated Cashflow Statement

for the year ended 24 June 2009

	Notes	Unrestricted funds £000s	Restricted funds £000s	Endowed funds £000s	Totals 2009 £000s	Totals 2008 £000s
Net cash (outflow) / inflow from operating activities	a	(807)	2,153	95	1,441	2,800
Net cash inflow / (outflow) from capital expenditure and financial investment	b	519	(2,109)	107	(1,483)	(3,142)
		(288)	44	202	(42)	(342)
Management of liquid resources	c	(28)	(12)	-	(40)	245
(Decrease) / increase in cash in year	d	(316)	32	202	(82)	(97)
a) Reconciliation of changes in resources to net inflow from operating activities						
Net incoming / (outgoing) resources before revaluations		(1,264)	1,543	95	374	847
Depreciation		899	556	-	1,455	1,323
(Profit) / loss on disposal of fixed assets		(352)	-	-	(352)	3
(Increase) / decrease in stocks		(44)	-	-	(44)	63
(Increase) / decrease in debtors		(265)	54	-	(211)	(1,101)
Increase in creditors		219	-	-	219	1,665
Net cash (outflow) / inflow from operating activities		(807)	2,153	95	1,441	2,800
b) Capital expenditure and financial investment						
Payments to acquire tangible fixed assets		(1,396)	(1,059)	-	(2,455)	(3,137)
Receipts from sales of fixed assets		378	-	-	378	-

Purchase of investments	(6,559)	(385)	(8,974)	(15,918)	(13,292)
Receipts from sales of current investments	-	-	1,768	1,768	-
Receipts from sales of fixed asset investments	6,559	571	7,614	14,744	13,287
Transfer between funds	-	301	(301)	-	-
Change in amounts due between funds	1,537	(1,537)	-	-	-
Net cash inflow / (outflow) from capital expenditure and financial investment	**519**	**(2,109)**	**107**	**(1,483)**	**(3,142)**
c) Management of liquid resources					
Increase / (decrease) in short-term deposits	28	12	-	40	(245)
d) Reconciliation of net cash flow to movements in net funds					
(Decrease) / increase in cash in year	(316)	32	202	(82)	(97)
Increase / (decrease) in short-term deposits	28	12	-	40	(245)
Movement in net funds in year	(288)	44	202	(42)	(342)
Net funds at 24 June 2008	3,662	2,624	79	6,365	6,707
Net funds at 24 June 2009	**3,374**	**2,668**	**281**	**6,323**	**6,365**

Notes to the Financial Statements

for the year ended 24 June 2009

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 and works of art, 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, and other items of artwork and silver relating to the history of surgery or commemorating events in the College's history. Freehold land and buildings are shown in the *Consolidated Balance Sheet* at historic cost. Capital projects that 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
Freehold buildings	nil
Plant and refurbishment	10%
Furniture, fittings and vehicles	25%
Computer equipment	25%

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 for depreciation would not be material 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, 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 that 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 that 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 – The consolidated accounts include the activities, assets and liabilities of the College's fully 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 £205,000 (2008: £203,000).

2. Reallocated support costs

		Direct costs £000s	Grants made £000s	Allocated support costs £000s	Totals 2009 £000s	Totals 2008 £000s
Cost of generating funds						
Fundraising costs		286	-	39	325	318
Investment management fees		216	-	-	216	272
Residential, conference and other trading costs		1,499	-	1,073	2,572	2,471
		2,001	-	1,112	3,113	3,061
Charitable expenditure						
Education and courses		6,378	-	626	7,004	6,500
Standards, regulation and examinations		5,945	-	781	6,726	6,371
Research grants		184	1,556	97	1,837	2,214
Clinical Effectiveness Unit and other projects		1,329	-	189	1,518	1,419
Museums and library		1,515	-	618	2,133	1,885
Communications and publications		1,554	-	108	1,662	1,524
Other professional activities		1,489	-	638	2,127	2,008
		18,394	1,556	3,057	23,007	21,921
Governance		**579**	**-**	**114**	**693**	**677**
Total		**20,975**	**1,556**	**4,283**	**26,813**	**25,659**
Support costs and basis of allocation						
Premises and utilities	Floor area occupied			2,527		2,250
Human resources	Number of staff employed			305		447
Finance services	Budgeted expenditure			575		577
IT and systems support	Equipment and support provided			876		885
				4,283		**4,159**

3. Research grants (excluding support costs)

Purpose of grant	2009 Number awarded	2009 Total amount £000s	2008 Number awarded	2008 Total amount £000s
Research fellowships				
Liabilities at start of year		*(675)*		*(1,044)*
Paid in year		*1,241*		*2,252*
Liabilities at end of year		*798*		*675*
Charge for year	49	1,364	45	1,883
Other research projects				
Liabilities at start of year		*(360)*		*(411)*
Paid in year		*112*		*126*
Liabilities at end of year		*399*		*360*
Charge for year	3	151	3	75
Scholarships	16	15	5	5
Travel	15	26	20	38
Total	**83**	**1,556**	**73**	**2,001**
Administration of research fellowships and other research projects		281		213
Research expenditure shown on Statement of Financial Activities		1,837		2,214

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

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 £423,000 (2008: £381,000) 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

	2009	2008
Number of staff employed by the College at 24 June	291	289

	£000s	£000s
Staff costs in year to 24 June:		
Gross pay	9,125	8,913
Employer's statutory contributions	872	778
Employer's pension contributions	946	875
Total staff costs	10,943	10,566

At 24 June the number of employees receiving salaries in the following bands was as follows:		
£60,000 to £70,000	5	5
£70,001 to £80,000	4	4
£80,001 to £90,000	2	2
£100,001 to £110,000	1	1
£110,001 to £120,000	-	1
£120,001 to £130,000	1	-

12 (2008: 12) employees are members of the USS pension scheme, while 1 (2008: 1) is a member of the NHS pension scheme.

	£000s	£000s
Included in *Governance* costs are:		
Auditor's remuneration – audit fees – The Royal College of Surgeons of England	36	37
Auditor's remuneration – audit fees – Hunter Trading Ltd	2	3

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 2008	3,354	693	13,393	1,882	5,482	24,804
Reclassification of assets	-	-	6,472	-	(6,472)	-
Disposals	(2)	(79)	(600)	(143)	-	(824)
Additions	-	65	165	308	1,917	2,455
Balance 24 June 2009	**3,352**	**679**	**19,430**	**2,047**	**927**	**26,435**
Accumulated depreciation						
Balance 25 June 2008	-	577	9,530	1,331	-	11,438
Disposals	-	(59)	(597)	(143)	-	(799)
Charge for year	-	44	1,170	241	-	1,455
Balance 24 June 2009	**-**	**562**	**10,103**	**1,429**	**-**	**12,094**
Net book values						
at 24 June 2009	**3,352**	**117**	**9,327**	**618**	**927**	**14,341**
at 24 June 2008	3,354	116	3,863	551	5,482	13,366

	Unrestricted funds £000s	Restricted funds £000s	Endowed funds £000s	Totals 2009 £000s	Totals 2008 £000s
6. Debtors					
Taxation recoverable	16	3	-	19	15
Other debtors	3,298	260	-	3,558	3,329
Prepayments	98	-	-	98	120
	3,412	**263**	**-**	**3,675**	**3,464**
7. Cash and short-term deposits					
Cash in hand	13	-	-	13	18
Current and instant access accounts	1,530	2,654	281	4,465	4,542
Short-term deposit accounts	1,831	14	-	1,845	1,805
	3,374	**2,668**	**281**	**6,323**	**6,365**
8. Creditors					
Amounts falling due within one year					
Other creditors	4,476	-	-	4,476	4,232
Taxation and social security	347	-	-	347	285
Deferred income	3,629	-	-	3,629	3,146
	8,452	**-**	**-**	**8,452**	**7,663**
Amounts falling due after more than one year					
Other creditors	190	-	-	190	760
	190	**-**	**-**	**190**	**760**
9. Deferred income					
Balance brought forward	3,146	-	-	3,146	2,574
Income arising during the year	19,158	8,330	182	27,670	27,078
Released to Statement of Financial Activities	(18,675)	(8,330)	(182)	(27,187)	(26,506)
Balance carried forward	**3,629**	**-**	**-**	**3,629**	**3,146**

10. Investments

Quoted securities at market value	20,257	1,047	20,462	41,766	53,652
Deposits with Newton Investment Management	1,286	46	2,260	3,592	2,418
Investment property at market value	1,650	-	-	1,650	1,650
Transfer of investments between funds	(3,280)	3,280	-	-	-
Market value	**19,913**	**4,373**	**22,722**	**47,008**	**57,720**
Movement in year					
Market value at 2 June 2008	27,433	3,309	26,978	57,720	65,175
Additions at cost	6,559	385	8,974	15,918	13,292
Disposals at sale price	(6,559)	(571)	(7,614)	(14,744)	(13,287)
Property to be sold within one year	-	-	-	-	(1,700)
Change in transfer of investments between funds	(1,537)	1,537	-	-	-
Net (loss) / gain on investments in year	(5,983)	(287)	(5,616)	(11,886)	(5,760)
Market value at 24 June 2009	**19,913**	**4,373**	**22,722**	**47,008**	**57,720**
Cost at 24 June 2009	21,291	1,124	21,944	44,359	47,566
Unrealised gain at 24 June 2009	(1,378)	3,249	778	2,649	10,154
Realised gains / (losses) on historic cost in year	**(1,228)**	**(72)**	**(1,400)**	**(2,700)**	**904**

At the year end, the market value of UK investments was £40,243,000 (2008: £48,364,000) and overseas investments was £6,765,000 (2008: £11,056,000).

As detailed in note 1(i), the common investment fund is incorporated into these financial statements.

Investment in subsidiaries

Hunter Trading Limited – The College holds the entire issued £1 share capital of Hunter Trading Limited, which markets those 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 £1,856,000 (2008: £1,878,000), its expenditure was £1,651,000 (2008: £1,675,000) and the profit before tax of £205,000 (2008: £203,000) has been transferred to the College under a profit-shedding covenant. The net assets of Hunter Trading Limited were £1 (2008: £1).

11. Permanent endowment and other restricted funds

	Permanent endowment funds				Other restricted funds			
	Balance 2008 £000s	Increases £000s	Decreases £000s	Balance 2009 £000s	Balance 2008 £000s	Increases £000s	Decreases £000s	Balance 2009 £000s
Dental Science Research Fund	2,136	-	450	1,686	465	93	86	472
Rank Chair of Physics in Surgery	2,031	-	428	1,603	(300)	79	91	(312)
RCSE Cancer Research Fund	3,737	-	788	2,949	(98)	145	100	(53)
RCSE Biochemical Research Fund	795	-	168	627	223	36	190	69
Darlow Research Fellowship	102	-	21	81	36	5	-	41
RCSE Research Fund	7,767	-	1,638	6,129	273	492	519	246
RCSE Education Fund	5,510	20	1,132	4,398	168	169	194	143
RCSE Museums Fund	15	-	3	12	101	4	21	84
Groves Bequest for Museum	443	-	93	350	5	17	18	4
MacRae Webb-Johnson for Hunterian	762	24	161	625	327	37	49	315
George Qvist Fund for Hunterian	444	-	94	350	4	17	18	3
RCSE Library Fund	1,742	-	367	1,375	11	68	71	8
RCSE Prize Fund	123	-	26	97	121	8	23	106
Preiskel Fund	-	-	-	-	19	2	3	18
HS Morton Travelling Fellowship	425	-	90	335	161	20	111	70
Sims Commonwealth Travelling Fellowship	134	-	28	106	55	7	5	57
Ethicon Travelling Fellowship	-	-	-	-	172	7	47	132
RCSE Scholarship Fund	108	-	23	85	53	6	25	34
Witt Fund	-	182	-	182	-	3	-	3
Modi Fund	-	-	-	-	402	66	119	349
Rishworth Fund for the *Annals*	106	-	22	84	1	4	4	1
John Kinross Fund	174	-	37	137	102	9	-	111
President's Finch Fund	1,696	55	358	1,393	125	69	113	81

Blond McIndoe Fund	-	-	-	-	571	22	145	448
Faculty of Dental Surgery								
Commemoration Fund	141	-	30	111	2	5	6	1
Moser Trust	365	-	77	288	122	17	1	138
Faculty of General Dental Practice (UK)								
Research Fund	-	-	-	-	3	-	-	3
Restricted grants and donations								
Cutner legacy for orthopaedics	-	-	-	-	350	-	51	299
Guyatt legacy for gastrointestinal diseases	-	-	-	-	228	12	75	165
Anatomy Project					256	-	31	225
Starrit Research Fellowships	-	-	-	-	128	-	-	128
Post-CCT Transplant Fellowships	-	-	-	-	-	1,227	41	1,186
Post-CCT Fellowship Project	-	-	-	-	-	162	57	105
JCST Selection Project	-	-	-	-	-	299	68	231
Hunterian Museum Project	-	-	-	-	1,631	10	249	1,392
Davies-Colley Lecture Room Project	-	-	-	-	146	-	24	122
Eagle Project	-	-	-	-	4,454	1,116	341	5,229
Other (individual balances under £100,000)	-	-	-	-	2,288	4,497	4,277	2,508
	28,756	281	6,034	23,003	12,605	8,730	7,173	14,162

*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 described in their title.

The increases for the endowed funds are represented by £182,000 for the Witt Fund. There was also a total of £99,000 transferred from restricted funds (see *Transfers* below).

The decreases for the endowed funds are represented by investment management charges of £87,000, a loss in investment market values of £5,616,000 and a gain on sale of investment property of £69,000. There was also a new loan of £400,000 authorised by Charity Commission Schemes, from the Education endowed fund to the Education restricted fund (see *Transfers* below).

Transfers

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

1. MacRae Webb-Johnson Fund: In 2003–2004 £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 fifth transfer of £24,000 was made in 2008–2009.

2. President's Finch Fund: In 2006–2007 £1.1 million was transferred from the President's Finch endowed fund to its restricted fund to support the Eagle Project. This sum is to be replaced by income arising on the President's Finch restricted fund at the rate of £55,000 a year for 20 years. The second transfer of £55,000 was made during 2008–2009.

3. Education Fund: In 2008–2009 £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 first transfer of £20,000 was made during 2008–2009.

12. Unrestricted funds

	2009 £000s	2008 £000s
Designated funds		
Represented by tangible fixed assets	7,484	7,013
'Capital' designated as necessary to provide income to support the College's charitable activities		
Brought forward	22,000	26,000
Decrease in year	(8,000)	(4,000)
	14,000	22,000
Total designated funds	21,484	29,013
Working reserves – the College and faculties:	4,210	3,928

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 decrease of £8.0 million (2008: decrease £4.0 million) derives in part from the decrease in the market value of unrestricted funds investments in the year to provide an amount approximately equivalent to 6–9 months of operational expenditure.

Working reserves are funds held for operational purposes of the College and its two dental faculties. Approximately £372,000 (2008: £355,000) 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 291 employees (2008: 289), 142 (2008: 140) are members of the Universities Superannuation Scheme (USS), 45 (2008: 47) are members of the Superannuation Arrangements of the University of London (SAUL) and 5 (2008: 6) 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 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 valuation was carried out using the projected unit method. The assumptions that 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 that 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 2009 the actuary has estimated that the funding level under the new scheme-specific funding regime had fallen from 103% to 74%. This estimate is based on the funding level at 31 March 2008, adjusted to reflect the fund's actual investment performance over the year and changes in market conditions. (Market conditions affect both the valuation rate of interest and also the inflation assumption, which in turn has an impact 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 14%. The College's total pension cost for this scheme in the year to 24 June 2009 was £768,882 (2008: £719,598).

SAUL: SAUL is subject to triennial valuations by professionally qualified and independent actuaries. The last available valuation was carried out as at 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:

	Past service	Future service
Valuation method – projected unit		
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 trustee 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 on 31 March 2011 when the above rates will be reviewed.

The level of contribution due by the College in the year was 13%. The College's total pension provision for this scheme in the year to 24 June 2009 was £136,040 (2008 – £126,713).

NHS: The College's total pension cost in respect of the NHS pension scheme in the year to 24 June 2009 was £40,858 (2008 – £23,307). 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 £101,213 (2008 – £121,486 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 2009	
Purpose:	
The main appeal of the College	441
For medical research and education	32
Notified after 24 June 2009 (to 11 August 2009)	
Purpose:	
The main appeal of the College	2
For medical research and education	-

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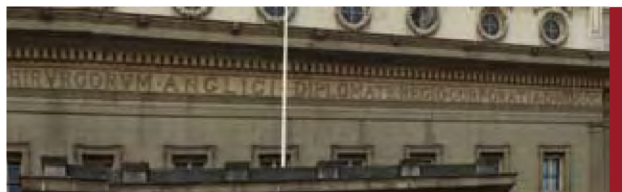

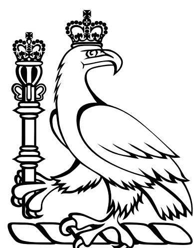

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