



BCPB

British Council
for Prevention
of Blindness



A photograph of an elderly man with a cane and a woman in a white uniform in a hallway. The man is in the foreground, wearing a blue patterned shirt and dark trousers, leaning forward and using a long wooden cane. He has a red and yellow headscarf. The woman is in the background, wearing a white short-sleeved shirt and dark trousers, walking away from the camera. The setting appears to be an indoor hallway with wooden pillars and a tiled floor.

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to the Trustees of the British Council
for Prevention of Blindness

Our Vision

To be widely recognised as a significant contributor to the prevention of blindness worldwide, by funding training and medical research.



“Although the word blindness is in the name of our charity and its prevention is the target of our efforts, it does not have a precise definition.”

► From the Chairman

The World Health Organisation gives a measure equivalent to the ability to see the top letter of the usual testing chart (this approximates to counting the fingers of an outstretched hand) when it is only 1 metre away. While this type of arbitrary numerical definition of central vision is essential for statistical purposes, it fails to take account of other defects in vision which contribute to the burden of distress and disability for individuals and their families. Narrowing of the field of vision is in many circumstances more hazardous than blurring of the central area and some people suffer from disabling dazzle or glare. The assessment of poor vision becomes even more difficult if we consider the rate or age of onset of loss of vision. A sudden but relatively modest deterioration in adult life may result in loss of livelihood or independence. In poor or isolated communities the lack of supporting services which could assist retraining and rehabilitation makes the burden worse. While the definition of blindness may not be precise, its effects are simpler to understand and they deserve our attention.

This charity provides two main types of support for those engaged in the fight against blindness. Firstly, we award doctoral fellowships which promote research aimed at the prevention of blindness and train professionals to lead regional and national eye care programmes. Secondly, we provide grants for researchers engaged in the initial phases of projects so that they can assemble sufficient results to apply elsewhere for substantial programme grants. In the assessment of applications for all our awards we are guided by the Vision2020 goals (see page 4).

You may be aware that trachoma and onchocerciasis are two of the commonest causes of world blindness but there are many less exotic conditions such as cataract and glaucoma which although readily treatable or controllable in our own society are still serious problems in many countries. This is especially so in

countries with limited resources available to provide the type of health service we take for granted. In addition, diabetic eye disease and age related macular degeneration are now so common in the developed world that services for their diagnosis and treatment are straining the health budgets in the richest of countries. In poorer countries their prevalence is rising fast.

More and more we are aware that the fight against world blindness is not just about exotic diseases in hot climates but about finding sufficient resources to deal with a whole range of disorders which affect every country.

Our projects span the range from UK laboratory research into the genetic basis of Age Related Macular Degeneration and possible treatments (see pages 16-17) to operational research in Malawi aimed at establishing the best method of identifying and referring blind children for treatment (see pages 10-11). On our website www.bcpb.org you will find a list of work published in the last 5 years by individuals we have supported. The publication of their work on this remarkably wide range of subjects makes the findings available for the benefit of others striving for the same goals.

I hope you will enjoy reading about our work in these pages and as ever my thanks are due to you, our supporters, for helping to make it possible.

Dr Jeffrey Jay CBE, BSc, FRCS, FRCOphth

VISION 2020: The Right To Sight (www.v2020.org) is a worldwide concerted effort to eliminate avoidable blindness by the year 2020.

The programme will enable all parties and organisations involved in combating blindness to work in a focused and co-ordinated way to achieve the common goal of eliminating preventable and treatable blindness.



▶ The BCPB and VISION 2020: The Right To Sight

- Somewhere in the world, a child goes blind with every passing minute
- In eight out of ten cases blindness is avoidable – treatable or preventable
- Blindness causes suffering not just for those people directly affected. The impact of lost productivity, as well as the direct costs of rehabilitation, has a significant effect on families and communities, particularly in developing countries, where 90% of blindness is concentrated.

The BCPB fully supports the aims of VISION 2020; The Right To Sight and we are committed to playing our part in eliminating avoidable and treatable blindness by funding:

- Practical research into the causes of blindness, more effective treatments, and preventive methods
- The training of eye care professionals from the developing world to enable them to implement blindness prevention programmes in their home countries.



▶ Research and Training Projects Currently Funded

Project	Total Cost of Project (£)
Dr W Mathenge, Sir John Wilson Fellowship: Prevalence And Causes Of Posterior Segment Eye Diseases In Kenya.	£180,000
Dr Victor Hu, Barrie Jones Fellowship: Blinding Trachoma - Studies On Pathogenesis And Control In Tanzania.	£175,588
Dr K Kalua, Sir John Wilson Fellowship: Childhood Blindness in Malawi - Identifying Children In Need.	£154,000
Dr Chitra Sambare, Sir John Wilson Fellowship: Unravelling The Genetic Basis Of Glaucoma In India.	£120,007
Professor Andrew Lotery: The effect of SERPING1 on Age Related Macular Degeneration.	£59,820
P Hossain: Negative Regulators of Interleukin-1 β & Toll-Like Receptor-4 Signalling: A Therapeutic Approach to Treat Global Blindness From Sight Threatening Corneal Inflammatory Disease.	£59,100
Professor Andrew Lotery: Discovery of Novel Immunogenetic Disease Pathways in Age Related Macular Degeneration.	£50,000
A Choudhary: Evaluation of thrombospondin-1 anti-angiogenic peptides for suppression of corneal vascularisation.	£47,165
Boulter Fellowships: part-funding of eye care professionals from developing countries to undertake MSc's in Community Eye Health at the International Centre for Eye Health, London School of Hygiene and Tropical Medicine.	£39,600
C Gilbert: Migration study of lens opacities in Bangladeshis living in London and in Bangladesh: a pilot study to refine methods.	£8,000
TOTAL	£893,280

Most of these projects are funded across more than one Financial Year

*Digital photography
of the eye.*



▶ Sir John Wilson and Barrie Jones Fellowships

Following on from the BCPB's success in funding Boulter Fellows (see pages 14-15) who train at Masters level in Community Eye Health, The Trustees decided in 2006 to set up a Doctoral Fellowship Programme. The Fellowships are fully funded by BCPB and lead to the award of PhDs and MDs. The aims of this project are:

- to provide top level eye care personnel in developing countries, in order to build knowledge and skills in eye care where they are most needed. Fellows from developing countries are selected partly on their ability and ambition to disseminate knowledge and skills through teaching and training.
- to foster links between UK institutions and those in developing countries, in order to facilitate a mutually beneficial transfer of knowledge in eye care.

To achieve these aims, an Advisory Panel was established (see page 7). For its first three years Professor Andrew Dick of Bristol University chaired the Panel. From June 2009 it has been chaired by Professor James Morgan, Professor of Ophthalmology at Cardiff University.

Two types of Fellowship are offered. Barrie Jones Fellowships are awarded to UK based Fellows who carry out research in a developing country; Sir John Wilson Fellowships are awarded to students from developing countries who come to the UK to carry out research.

*Professor
James Morgan.*



▶ Advisory Panel

Professor Simon Harding

FRCS, FRCOphth, MD, Professor of Clinical Ophthalmology, Honorary Consultant Ophthalmologist and Head, Ophthalmology Research Unit, School of Clinical Sciences, University of Liverpool

Dr Caroline MacEwen

Head of Department & Consultant Ophthalmologist, Ninewells Hospital, Dundee and Vice President of the Royal College of Ophthalmologists

Peter Ackland

(Overseas Advisor)
Chief Executive Officer,
International Agency for
the Prevention of Blindness

Mr Michael Clark

FRCS, FRCOphth
Reader in Ophthalmology,
Claremont Wing Eye Dept
Royal Victoria Infirmary
Newcastle upon Tyne

Parul Desai

MSc, PhD, FRCS, FRCOphth,
MFPHM Consultant in
Ophthalmology and Public
Health, Moorfields Eye
Hospital, London

Professor Harminder Dua

PhD, FRCSE, FRCOphth
Professor of Ophthalmology,
University of Nottingham

Peter Francis

PhD, FRCOphth
Consultant Ophthalmologist,
St Thomas' Hospital, London

Mr James Kirwan

FRCOphth
Consultant Ophthalmologist,
Queen Alexandra Hospital
Portsmouth

Professor James Morgan

MA, DPhil, FRCOphth
Reader of Ophthalmology,
Cardiff University
(Chairman, from June 2009)

Mr Ian Murdoch

BSc, MSc, MD, FRCS, FRCOphth
Consultant Ophthalmologist,
Moorfields Eye Hospital, London
Senior Lecturer, Institute of
Ophthalmology, London
Honorary Senior Lecturer,
London School of Hygiene and
Tropical Medicine

Miss Giuliana Silvestri

MD, FRCP (Ed), FRCS, FRCOphth
Head of Department,
Ophthalmology
Queens University Belfast

Professor Miles Stanford

MD, FRCS, FRCOphth
Consultant Ophthalmologist,
St Thomas' Hospital, London,
Professor, University of London

*Dr Mathenge
(top row, second from right)
and her team.*



► Sir John Wilson Fellowships

Kenya: Research and Treatment Programme Focusing On Over 50's

The BCPB awarded its first Sir John Wilson Fellowship to Dr Wanjiku Mathenge of Kenya in February 2006. Dr Mathenge's research focused on older patients in the Nakuru district of Kenya. The research was supervised by Professor Allen Foster at the International Centre for Eye Health (ICEH), based at the London School of Hygiene and Tropical Medicine (LSHTM). It will lead to the award of a PhD and will equip Dr Mathenge with the knowledge and skills she needs to lead the development of eye care within Kenya.

As cataract, trachoma, vitamin deficiency and river blindness are tackled, the proportion of blindness due to diseases such as glaucoma and age related macular degeneration (AMD), which affect the posterior segment of the eye and older patients, and which are common in developed countries, is increasing in lesser developed countries (LDCs). At present little is known about their distribution or control in Africa. Dr Mathenge's study investigates the burden of posterior segment eye diseases in the Nakuru district of Kenya by means

of a survey of 5000 people over 50 years old. Risk factors will be identified by comparing cases with the disease to disease-free controls. After counselling for treatment, cases and disease-free controls were followed up after 1 year to assess the barriers to uptake of services, the results of treatment and the progression of disease.

Dr Mathenge writes:

“ After almost exactly 12 months of field work I finally finished collecting data at the end of November 2008. Out of the expected sample size of 5000 individuals I managed to examine 4396 people - a turnout of 88 percent. This was a great achievement, given that my study took place right in the middle of the political crises in Kenya, which resulted in major displacement of people and general insecurity, not just for the study participants, but also for me and my survey team.



I have to say that I had completely underestimated the magnitude of the task I had undertaken, especially as my study protocol meant that I had to personally examine every individual. I also underestimated the difficulties of travelling with and setting up sensitive electronic equipment through forests, valleys, and across rivers every single day. I now appreciate the value of buying high quality equipment. And I realise how lucky I was to receive a Fellowship from BCPB that allowed me to purchase the best for the job.

I returned to London in January 2009 and began the task of making sense of all the information I had collected.

I have now finished and handed in my thesis and I am waiting to be called for the viva any time after my two external examiners, Dr Ian Murdoch of University College London and Professor Collin Cook of University of Cape Town, finish marking it. I have to say that the most mentally exhausting part of writing this thesis was the final part- putting it all together into one document. I guess it is because by that stage one feels the end is so near but it actually takes an awfully long time to get it all together in a way that flows and tells the story of the project. Eventually when it was all done what struck me most was just how big it was. I felt sorry for the 2 external examiners.

I am going to submit every chapter as a separate paper for publication. One paper has already been accepted and published. Interestingly it has nothing to do with eyes but represents to the best of my knowledge the first truly population based data on chronic diseases in Kenya. Altogether I should publish about 20 papers out of this work.

All being well, I will shortly proudly become one of the very first ophthalmologists in Africa to hold a PhD. I owe that to BCPB and their confidence in me. I have now relocated to Rwanda and have become the Head of the Department of Ophthalmology at the Kigali Health Institute. My first mandate is to evaluate the existing course, revamp it and make it more relevant for the Rwanda Eye care system as well as suitable for the whole Eastern Africa Region. I am also just concluding a very exciting business plan to run a Centre of excellence in Eye Care for the Region comprising a state of the art eye clinic, an eye bank and a teaching program for several eye care cadres.

Recently a proposal has been submitted through ICEH to have another PhD student follow up the Nakuru cohort and look at incidence of eye diseases. I will co-supervise the student if his application for funding is successful. ”

Key outcomes of the project so far:

- 434 health workers and volunteers trained
- Over 950 children examined
- Number of cases referred for cataract in Blantyre has increased from 50-60 to almost 100 per year during the last 3 years
- Trained Volunteers are twice as effective as health workers at finding and identifying children at risk of blindness
- Blantyre Institute for Community Ophthalmology (BICO) was established in 2008: now with a full time Project Co-ordinator.



▶ Childhood Blindness In Malawi: Identifying Children In Need

In January 2007 the BCPB Advisory Panel awarded the second Sir John Wilson Fellowship to Dr Khumbo Kalua of Malawi. He is researching better methods of identifying blind children in rural locations, in order to get them treatment and save their sight. The Fellowship will provide around £150,000 of funding to help save the sight of children in this part of Africa. In 80% of cases the blindness is avoidable – preventable or treatable. But the children do not get the help they need - partly because they are simply not identified and referred for treatment.

Dr Kalua's research project tests a new method of identifying blind children in the community using 'key informants'. This involves training people from the villages who know their community well, are willing to help identify blind children, have time to do the job - and are happy to do it without payment.

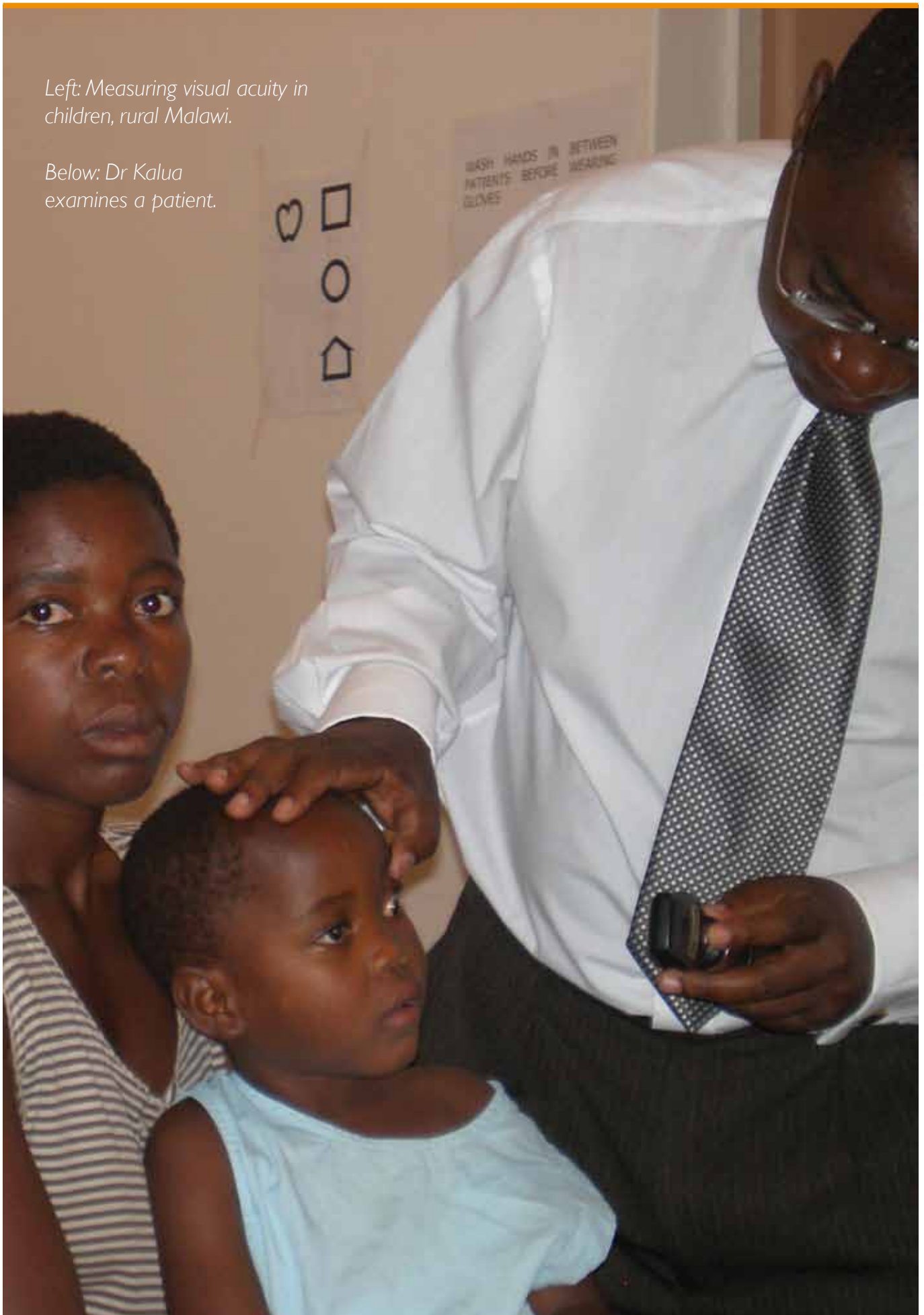
In a pilot study, Dr Kalua himself trained a group of key informants for a day, and in the following 6 weeks they successfully identified around 40 blind children, who were then referred for treatment. The new method will be tested against another method using trained primary healthcare workers. Alternative methods of referral will also be evaluated.

The project will not only treat many more blind children, but will also help to develop sustainable systems and procedures to prevent childhood blindness in Malawi. The lessons learned will be applicable elsewhere in Sub-Saharan Africa, where there are some 320,000 blind children at present.

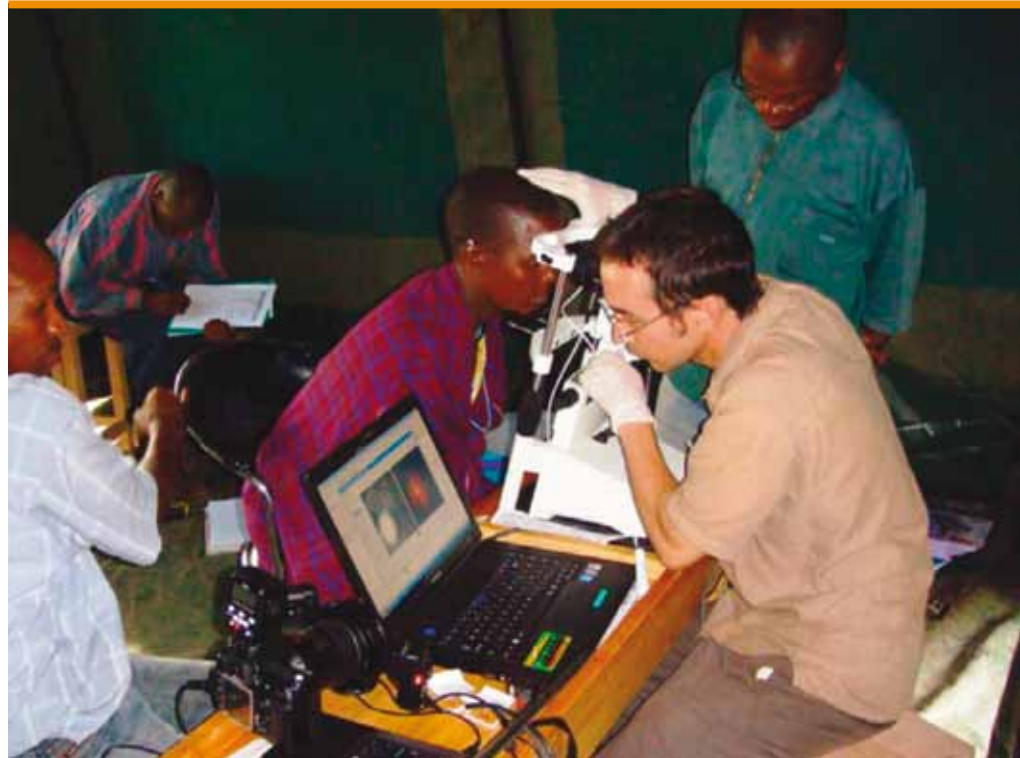
As well as providing these important research and treatment outcomes, it will enable Dr Kalua to attain skills in prevention of blindness at Doctorate level. This will equip him to lead the development of eye care programmes in his country and the surrounding region. Dr Kalua aims to establish a fully operational community eye department at the University of Malawi, which will have a big impact in national blindness prevention.

Left: Measuring visual acuity in children, rural Malawi.

Below: Dr Kalua examines a patient.



Confocal microscopy being performed by Dr Hu.



▶ Dr. Victor Hu: Trachoma in Tanzania

Trachoma is the leading infectious cause of blindness worldwide. Infection with *Chlamydia trachomatis* triggers a poorly understood inflammatory response in children, mainly in the conjunctiva (the membrane lining the inner surface of the eyelid). These children are then at risk of developing scarring complications: the eyelashes turn in and rub against the eye which leads to blindness. It is unknown whether current control measures, including antibiotic treatment, will halt this process as scarring develops over many years.

There are at least 1.3 million people estimated to be blind from trachoma, with many more having poor vision, and 8.2 million with painful, in-turned lashes scratching against the eye. There are an additional 40 million at risk of blindness in endemic countries. The disease is largely found in poor, rural communities in developing countries, particularly in Sub-Saharan Africa.

The aims of the project are:

- to improve our understanding of how blinding trachoma develops and progresses, which is necessary for the development of blindness prevention measures.
- to develop and validate research tools to identify early markers for progressive disease.
- Finally, these tools will be used to investigate whether current interventions result in a reduction in factors associated with progressive scarring and will help to lead to the development of new trachoma control strategies.



Patients having their demographic details recorded.

Dr Hu writes:

“ I have performed a census of the population of three adjacent villages in the Kilimanjaro region of northern Tanzania which were endemic for trachoma. There were 3626 adults and, along with a field team, I went house to house to examine these adults for the presence of scarring from trachoma. We examined 2418 people and found 862 had scarring. A proportion of these were then recruited into studies for the research programme, after having given consent. The first study was one comparing 360 people with trachomatous scarring and 360 people without trachoma, which has been completed. We are also following a group of 800 people with scarring of the conjunctiva for 2 years, who are being examined regularly. For these 2 studies a detailed examination was performed including digital photography, checking infection status, examination with a special confocal microscope to look at changes in cells/tissues, and measuring the levels of inflammatory signalling markers at a molecular level. As well as collecting the samples I have also been working in the lab, processing the samples. This has involved extracting genetic material and then performing polymerase chain reaction to amplify this material so that it can be measured.

This has enabled us to look at the level of different inflammatory molecules which may be important in driving the scarring process.

The cohort of 800 people with trachomatous scarring are being examined every 6 months and the final examination will take place in the first half of 2011. We will then be able to look at factors causing progression of disease at macroscopic, microscopic and molecular levels.

We plan to carry out surgical camps in the community for in-turning eyelashes which, as well as helping those people being operated on, will give us another way of studying the disease using laboratory microscopes. We will be able to gain a very detailed description of the conjunctival cellular and tissue changes in scarred eyelids. We will also be able to validate our findings with the confocal microscope and we can use special immune staining techniques to look at which cells are important in the scarring process. We will be collaborating with the Institute of Ophthalmology in processing the samples and exploring the laboratory response to potential medications. ”

The BCPB's Boulter Fellowship scheme has been running since 1982. The scheme is named after the late Eric Boulter, one of the founders of BCPB. Its purpose is to enable eye care professionals from the developing world to train in Britain to acquire the specialist skills so greatly needed in their country of origin.



▶ The Boulter Fellowship Programme

The BCPB makes a contribution towards both tuition and living expenses for the Boulter Fellows, who come to London to undertake a Master of Science Degree in Community Eye Health (CEH) at the International Centre for Eye Health, within the London School of Hygiene and Tropical Medicine. Training in Community Eye Health extends the trainees' expertise in clinical ophthalmology, which is applied to individual patients, to cover the eye health of whole populations – how their needs can best be evaluated and met.

The VISION 2020 global programme for the elimination of avoidable blindness (see page 4) has human resource development as a key component. This course is designed in keeping with the objectives, priorities and strategies of VISION 2020 and aims to equip eye care professionals with the knowledge and skills they need to implement the VISION 2020 programme at country and district level. The students, once trained, return home to help set up and manage eye care programmes to save and restore sight.

Dr Tafida writes:

“ Following publication of the Nigeria National Blindness and Visual Impairment Survey, in which I participated, there is a promising future for the Ophthalmic Community in Nigeria. With advocacy, commitment and careful planning we aim to move the State programme towards what it ought to be and what the people deserve. We've already drawn up our Vision2020 Strategic Plan and have started implementing this at the State level. With support and determination, we aim to be amongst those to celebrate the elimination of trachoma, just as we are seeing the end of onchocerciasis. It's my hope that the MSc CEH programme will give me the leverage to steer eye care in my State specifically and in the country in general, towards the Vision2020 objectives of eliminating avoidable blindness. My knowledge is being sharpened daily - and by the time I return that knowledge will be part of the arsenal helping my colleagues and I to tackle the issues at hand! ”



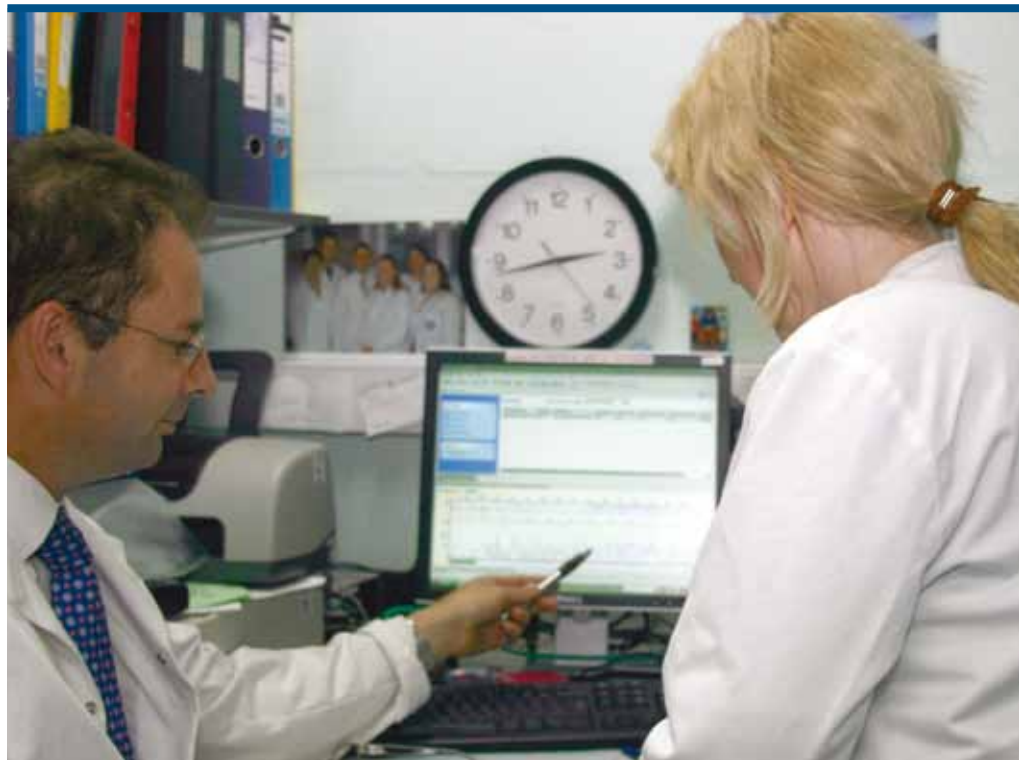
Left:
Dr Abubakar Tafida.

Right:
Dr Chimgee Chuluunkhuu
examines a patient.

▶ Boulter Fellows 2009 -2010

Boulter Fellows	Place of work	Country or region of focus
Dr Milka Mwafiri	Lecturer, Muhimbili University	Tanzania
Dr Sandeep Buttan	Consultant, Anterior Segment and Community Ophthalmology, Dr Shroff's Charity Eye Hospital, New Delhi	India
Josephine Adekoya	Lecturer, Consultant, Lagos State University Teaching Hospital/College of Medicine, Lagos	Nigeria
Dr Sunu Dulal	Himalaya Eye Hospital	Nepal
Dr Abubakar Tafida	Health Services Board, Jigawa State, Outreach Programmes, Lecturer and Consultant at Teaching Hospital, Kano	Nigeria
Dr Chimgee Chuluunkhuu	Staff Ophthalmologist at Bolor Melmii Eye Hospital.	Mongolia

*Professor Lotery
and colleague at
work in the lab.*



► Professor Andrew Lotery:

Genetic Keys to Age Related Macular Degeneration

Age Related Macular Degeneration (AMD) is the commonest cause of blindness in people over 65 in the UK. In most cases, treatment options are limited. But Professor Andrew Lotery and his team at Southampton University have been discovering new ways to fight the disease. They are examining genes linked to the disease and have already made findings which may result in new treatments.

Their work has helped to confirm that there is a genetic link to the disease. In fact, the disease has a genetic cause in up to 75% of cases.

Findings suggest that there may be a link to the body's immune response and to related inflammation. The inflammatory response occurs when tissues are injured by bacteria, trauma, toxins, heat, or any other cause. Chemicals are released by the damaged tissues, which cause blood vessels to leak fluid into the tissues, leading to swelling. This isolates the foreign substance from further contact with body tissues. The chemicals also attract white blood cells that "eat" micro-organisms and dead or damaged cells.

This inflammatory process take place within the eye in tissue called the retinal pigment epithelium and it is this which may cause AMD. The research indicates that a particular genetic protein whose job it is to put the brake on this inflammation may be faulty in many people who go on to develop AMD.

Professor Lotery's team have confirmed that the complement factor H gene is an important cause of AMD and have begun to look at how having this faulty gene influences response to treatments available now. People with the faulty gene have different forms of wet AMD and seem to respond differently to laser treatment. The team has recently confirmed that another gene, SERPING 1, also has an important role in the disease. The findings need to be confirmed in larger studies, but suggest that testing patients for these gene changes may be useful in the future. Modern advances in gene testing technology make this feasible.



DNA Strands.

Professor Lotery writes:

“Age-related macular degeneration (AMD) affects a very small area at the back of the eye responsible for detailed sight: the macular. Disruption of this area causes a loss of central vision and can occur quite suddenly or, in the majority of cases, much more slowly over several years. Until relatively recently, very little was known about the cause, or causes of this blinding disease currently affecting 1 in 3 people over the age of 75 in the UK and other developed countries. Deposits in the layers of tissue at the back of the eyes of AMD patients have given some clues as to the mechanisms involved. Researchers have been able to study the nature of these protein and fatty deposits, many of which are regulators or signalling molecules. Dr Goverdhan, a clinical research fellow, who finished his academic training with Professor Lotery last year, found two such molecules to be associated with AMD disease. Both interleukin-8 and a killer cell receptor have faults at the level of the patients DNA and can lead to AMD in later life.

Since 2005, scientists from all over the world have become increasingly aware of the role of genetics in AMD and how family history may play a role. However, it has been a surprise to discover that it is the genes of the body's defence mechanisms and not the eye itself that appear to be responsible. Some of the

first genes implicated are those responsible for part of our immune defences known as the alternative complement pathway. These help the body detect and eliminate foreign particles and reduce infection. My team, together with local and international collaborators, are the first to suggest that another pathway might also be involved. We have found that a regulatory element at the beginning of the classical complement pathway is also implicated in AMD. Our work now focuses on determining how a fault in the SERPING1 gene can cause the inflammation and scarring seen in AMD eyes. It is hoped that this knowledge will lead to new drug therapy targets for AMD patients in the future.

We now wish to explore the possibility that gene number may be an important factor in disease development, perhaps being as detrimental to sight as faulty genes. This concept is known as copy number variation and the AMD research team at Southampton look forward to expanding upon their initial findings over the months ahead. ”

Income & Expenditure:

Year ended 31st March 2010

	Unrestricted Funds	Restricted Funds	Total 2010	Total 2009
INCOMING RESOURCES	£	£	£	£
Incoming resources from generated funds:				
Voluntary Income				
Donations (including gift aid)	30,324	58,000	88,324	87,400
Legacies	525,137	45,562	570,699	210,073
Investment income	5,706	–	5,706	38,294
	561,167	103,562	664,729	335,767
RESOURCES EXPENDED				
Cost of Generating Funds				
Fund-raising and publicity	30,531	–	30,531	30,078
	30,531	–	30,531	30,078
Charitable activities	255,813	53,550	309,363	257,182
Governance costs	20,158	–	20,158	19,942
	306,502	53,550	360,052	307,202
TOTAL RESOURCES EXPENDED				
	254,665	50,012	304,677	28,565
NET INCOMING RESOURCES				
Unrealised gain on investments	999	–	999	118
	255,664	50,012	305,676	28,683
NET MOVEMENT IN FUNDS				
	733,521	1,550	735,071	706,388
FUND BALANCES BROUGHT FORWARD				
	£989,185	£51,562	£1,040,747	£735,071

▶ Balance Sheets:

Year ended 31st March 2010

	Group 2010	Group 2009
FIXED ASSETS	£	£
Tangible Assets	333	130
Investments	7,097	6,098
	7,430	6,228
CURRENT ASSETS		
Debtors	427,511	100,061
Investment / Bank Deposits	649,553	693,246
Cash at bank and in hand	340,695	233,164
	1,417,759	1,026,471
CREDITORS		
Amounts falling due within one year:		
Committed grants	282,059	156,457
Other creditors	–	–
Accruals	29,133	18,842
	311,192	175,299
NET CURRENT ASSETS	1,106,567	851,172
TOTAL ASSETS LESS CURRENT LIABILITIES	1,113,997	857,400
CREDITORS: AMOUNTS DUE AFTER ONE YEAR	73,250	122,329
NET ASSETS	£1,040,747	£735,071
Represented by:		
RESTRICTED FUNDS	51,562	1,550
UNRESTRICTED FUNDS		
Designated funds		
Boulter Fellowship Award Fund	39,600	39,600
BCPB Fellowship Award Fund	450,000	450,000
Fellowship Contingency	–	120,000
Other Awards	–	–
General Fund	499,585	123,921
	£1,040,747	£735,071

▶ Board of Trustees

The trustees during the year ended 31 March 2010 were:

Chairman

Dr Jeffrey Jay

CBE, BSc, FRCS, FRCOphth
Past President of Royal College
of Ophthalmologists

Honorary Secretary

Dr Claire Walker

BSc, PhD, MInstF

Honorary Treasurer and Acting Chairman (June 2008-June 2009)

Stephen Brooker

MA, FCA
Non-Executive Director,
East & North Herts NHS Trust
Chairman, Audit Committee of
the Law Society

Members of the Council

Miss Jacqueline Boulter BA

Managing Director
Yellow Hat Consulting Ltd

Professor Andrew Dick

BSc(Hons), MD, FRCP,
FRCS, FRCOphth
Chairman and Professor of
Ophthalmology, Academic Unit
of Ophthalmology and Head of
Research Department of Clinical
Sciences, University of Bristol.
Co-Editor of British Journal
of Ophthalmology.
(Resigned June 2009)

Dr Caroline Harper OBE

Chief Executive
Sight Savers International

Mr Richard Jackson

Solicitor and member of the
Government Legal Service,
Trustee of British Youth Opera.
(Resigned June 2009)

Mr James Morgan

MA, DPhil, FRCOphth
Professor of Ophthalmology,
Cardiff University

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**Registered Charity Number:
270941**

**Member of the Association
of Medical Research Charities**

Associated with:

The International Association
for Prevention of Blindness (IAPB)

The International Centre
for Eye Health (ICEH)

Auditors

Knox Cropper
8/9 Well Court,
London EC4M 9DN

Bankers

National Savings & Investments
Glasgow G58 1SB

HSBC Bank Plc
90 Baker Street
London W1M 2AX

Santander
201 Grafton Gate East
Milton Keynes
MK9 1AN

CAF
Birmingham Midshires
Pendeford Business Park
Wobaston Road
Wolverhampton WV9 5HZ

Supporting the BCPB

Our work in preventing blindness cannot take place without the generosity of individuals, trusts and companies.

BCPB
British Council
for Prevention
of Blindness

Gift Aid All gifts made to charity now qualify for tax relief. In effect this means that, simply by signing the declaration below, all your donations will increase in value, at no extra cost to you. For example, a donation of £25.00 in 2010-2011 will become £31.25, or more if you pay income tax at the higher rate.

Making a Will Whether you have already made a will or are thinking of doing so, please consider making a charitable bequest to the BCPB. Legacies can make an enormous difference to our work and what we can achieve.

Regular Donations By giving regularly, you can make it much easier for the BCPB to plan important projects - providing income we know we can rely on.

Website You can donate on-line at www.bcpb.org

To make a single or regular donation please fill in the appropriate sections below and send to the British Council for Prevention of Blindness, 4 Bloomsbury Square, London WC1A 2RP

SINGLE DONATION

Please tick the appropriate box

You can also make donations on-line. Simply go to www.bcpb.org/donations.html

With step by step instructions it is easy, fast and convenient.

Please accept my / our donation towards preventing blindness and restoring sight:

£25 £50 £100 £ _____

(whatever you can afford to help our work)

Cheque enclosed made payable to:
British Council for Prevention of Blindness

Please charge my

Mastercard Visa

Card Number

□□□□ □□□□ □□□□ □□□□

Expiry Date

□□□□

Name _____

Address _____

GIFT AID DECLARATION

Please tick the appropriate box

This will enable us to reclaim the tax you have paid on your donation: I would like all gifts to the British Council for Prevention of Blindness paid on or after the date of this declaration to be Gift Aid donations.

I pay tax at the basic rate higher rate

Signature _____

Date _____

Please note: You must pay an amount of UK Income Tax or Capital Gains Tax equal to the tax deducted from your donations for your gift to be eligible for Gift Aid.

BANKER'S ORDER FORM (For regular donations)

To (name of your Bank) _____

Your Bank's Address _____

Please pay: The British Council for Prevention of Blindness
4 Bloomsbury Square, London WC1A 2RP

the sum of £ _____

Post Code _____

amount in words _____

Bank Sort Code _____

Start Date* PLEASE ALLOW AT LEAST ONE MONTH FROM TODAY'S DATE

Your Account No. _____

And afterwards on the day same day each month/quarter/year until further notice (delete as appropriate).

Your Name and Address (Including Post Code) _____

***This cancels all previous orders.**

Signature _____

▶ Independent Auditors' Statement to the Trustees of the British Council for Prevention of Blindness

We have examined the summarised financial statements of the British Council for Prevention of Blindness on pages 18 and 19.

This statement is made solely to the Trustees, as a body in accordance with the terms of our engagement. Our work has been undertaken so that we might state to the trustees those matters we have agreed to state to them in this statement and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees as a body, for our work, for this statement, or for the opinions we have formed.

Respective responsibilities of trustees and auditors

The Trustees are responsible for preparing the summarised financial statements in accordance with recommendations of the charities SORP.

Our responsibility is to report to you our opinion on the consistency of the summarised financial statements with the full financial statements and Trustees' Annual Report. We also read the other financial information contained in the summarised annual report and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the summarised financial statements.

Basis of opinion

We conducted our work in accordance with Bulletin 1999/6 'The auditors' statement on the summary financial statement' issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In our opinion the summarised financial statements are consistent with the full financial statements and the Trustees' Annual Report of the British Council for Prevention of Blindness for the year ended 31st March 2010.

Knox Cropper
Registered auditors

22nd November 2010

Trustees' Statement

The Trustees confirm that the financial statements on pages 18 and 19 are taken from the full set of financial statements comprising the Trustees' Report and Accounts which were approved on 1st July 2010. The summarised financial statements may not contain sufficient information to allow a full understanding of the financial affairs of the British Council for Prevention of Blindness.

For further information the Annual Report and Accounts should be consulted. A copy of this document, upon which the auditors have reported without qualification, has been delivered to the Charity Commission and is available on request from the British Council for Prevention of Blindness, 4 Bloomsbury Square, London, WC1A 2RP.

By order of the Trustees.

Date: 1st July 2010



British Council
for Prevention of Blindness
4 Bloomsbury Square,
London, WC1A 2RP

Telephone: 020 7404 7114
Email: info@bcpb.org
Website: www.bcpb.org

BCPB
British Council
for Prevention
of Blindness

Registered charity number: 270941

