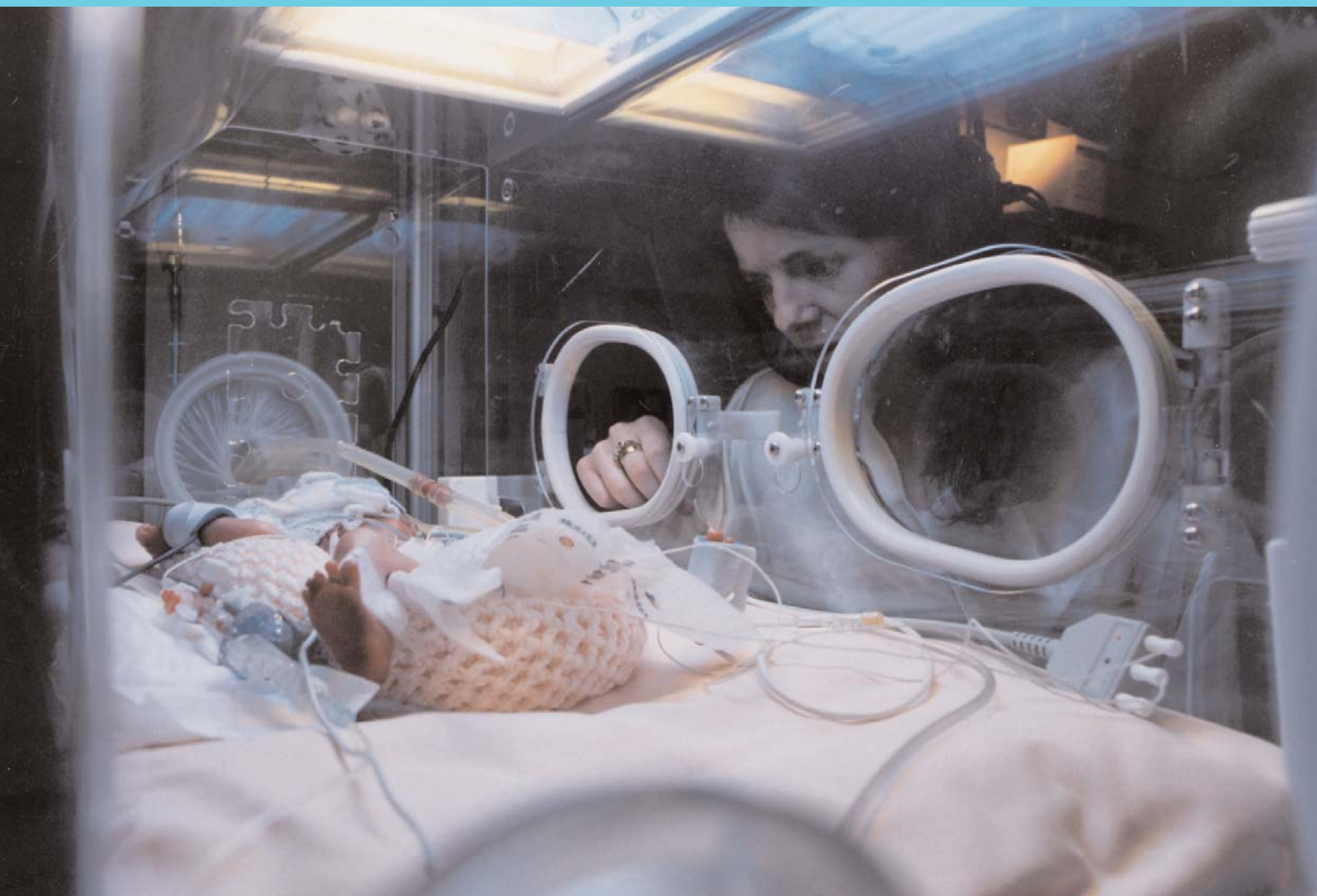
BRITISH ASSOCIATION OF PERINATAL MEDICINE

Founded 1976

Annual Report 2003



Message from the President

My first year as President of BAPM has seen many positive developments that largely reflect the energy of the Executive Team and our committed members during the year before I took up office. The publication of the Report of the Neonatal Intensive Care Services Review Group [April 2003] came as a consultation paper after a seemingly endless delay. I was beginning to develop an affection for the rumours and humour associated with "When's the report coming out?"

Whatever the result of the consultation it is essential that we build on the excellent work done by the Review Group and engage our SHA's and PCT's to ensure that we see the development of safe and managed networks, rather than under-resourced special care baby units with deskilled staff and no guarantee of assistance when it is needed. Although the consultation paper focuses on neonatal intensive care, the network arrangements must take into account the profile and distribution of maternity units, and general and specialist paediatric services including paediatric surgery. As we don't start with a blank sheet of paper some compromises will have to be made and a measured approach will be needed in order to bring about the expected improvement in services for babies and their parents.

On a national level, promoting improvements in perinatal care also depends on our success in creating effective links with a range of other professional organisations. The forthcoming joint scientific meeting with the Royal College of Obstetricians and Gynaecologists in September 2003 is something we need to build on. We are strongly supporting the emergent Association of Neonatal Nurse Practitioners, and our Honorary Secretary represented BAPM at their first conference. We continue a dialogue with the Neonatal Nurses Association and are represented at their annual meetings.

These, and other links, need to be exploited in more innovative ways. Given the likely expansion of the role of neonatal nurse practitioners or their professional equivalents, I hope that some neonatal units will want to develop perinatal education frameworks shared between neonatal nurses and doctors in training. This structured approach to perinatal education means more than simply joint teaching on ward rounds. Another area that awaits development is the need to test by rigorous research the results of introducing new models of neonatal service delivery – and here there is scope for examining a wide range of outcomes that reflect the arms of clinical governance, as well as clinical outcomes. These aspirations are more likely to be achieved when driven by professional organisations working together.

When the officers met in February 2003 to discuss ideas about the future direction of BAPM an agreed priority was to encourage more involvement of members in the organisation's activities. Our Honorary Secretary has outlined in his Annual Report how members can make important contributions to proposed sub-committees that will address matters such as guidelines, risk management, and a complex range of emerging issues around ethics, public expectation, and media interest. This will be discussed further at the AGM and I look forward to your support.

David Lloyd, our Honorary Treasurer, retires from office this year after serving since 1988. We thank him for fulfilling this role so expertly, coping with a growing membership, and keeping our finances healthy.

David Harvey, our Archivist, has kept our expanding archives in excellent order, as well as attending meetings of the Executive Committee. I was sad that he tendered his resignation from this office – not simply because we are losing our Archivist but because he is one of our Founding Members, Honorary Secretary from 1983-6, and he has contributed so much to our organisation.

Thanks also to outgoing representatives: Layla Al Roomi [Scotland]; Sunil Sinha [North of England and Wales]; and Peter Danielian, our obstetric representative.

Finally, I echo our Honorary Secretary's gratitude to Christine Cooper and Julia Wheal for their commitment and energy in dealing with an expanding administrative work load and for keeping the Officers in order.

Honorary Secretary's report

It may have always been like this and I had not noticed but to me this appears to be a time of great change for medicine in the UK with perinatal care right at the centre of this process. As a result, BAPM as an organisation has the potential to occupy an increasingly important role as the standard bearer for perinatal opinion in the clinical and political arena. In my report to the 2002 AGM, I flagged these increasing demands and the fact that we needed to adapt as an organisation in order to meet these challenges and be more responsive to our increasing membership. I hope all of you have felt that we have tried harder to involve and inform the wider membership particularly by increased use of e-mail and the website. However, it has become increasingly clear during the last twelve months that further changes are needed to both make BAPM more relevant as an organisation and more inclusive in terms of the membership. Therefore in my report, like last year, I want to concentrate on looking forward.

Committee structure

One issue that has emerged during the past 12 months, when we have tried to extend our activities and improve communication with members, is that our existing structure is very inefficient. By this I mean that virtually everything in terms of reviewing incoming correspondence and developing policy has to come through the Officers and the Executive. This often means that the relevant Officer is the rate-limiting step for any change since the calls on their time have been steadily increasing and, of course, they all have full-time jobs. Therefore, if we wish to become more active as an Association, it seems inevitable that we try to deal with this situation.

Our plans to do this will involve the establishment of a number of semi-autonomous sub-committees. Each sub-committee would be led by a Convenor and have, perhaps, 8-10 members. We will announce the establishment of each sub-committee and will ask for members to nominate themselves as Convenor of a particular group by contacting the Administrator with a brief description of any relevant experience and why they feel they would like to take on this particular role. I would anticipate that several members are likely to put themselves forward for the leadership of each sub-committee and therefore the Executive will choose each Convenor on the basis of the individual they feel is most appropriate. Each Convenor will serve for three years. The ordinary members of each sub-committee will be identified by a similar process but will be chosen by the Convenor in discussion with the Executive; they too will serve for three years (however we will try to allow for some staggering of the replacement process to ensure

continuity). It will be important to make sure that each sub-committee has a range of specialists represented (including non-medical members) and also covers the whole of the UK (each will have to have a specific Scottish and Welsh - and where possible Irish - representative). It is intended that each sub-committee will also include a member of the Executive. The actual sub-committees will meet face-to-face quite infrequently as most of their work can be done perfectly easily by email and telephone conference. In the long term, we envisage that, perhaps, seven or eight such sub-committees may be necessary but in the first instance, our suggestion is to establish just three. The remit of these groups will be:

1) **Guidelines** – to include consensus statements etc.

2) **Clinical excellence** – which will cover work in relation to standards, risk management and audit.

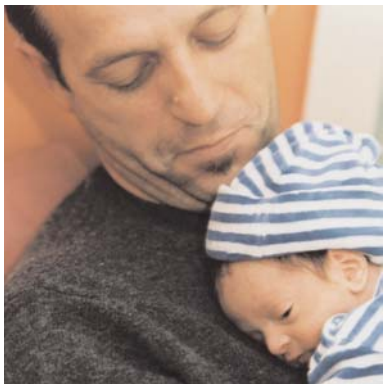
3) **Emerging issues** – developing policy in relation to both ethical and service issues that result from changes in public and or professional expectation. An example here would be the recent changes regarding what is expected in relation to consent.

I will not, here, go into the detail of what we envisage each sub-committee will be undertaking, however a clear workplan agreed with the Executive will be important. I would like to make the point that we see these groups not only continuing with our existing activity in these areas but also taking on new roles. To give just a single example, we would very much like to see the clinical excellence group develop a system whereby important risk management messages from across the whole country can be shared, in an anonymous fashion, via the BAPM website.

Clearly these groups will need a certain amount of administrative support and we hope to provide this in order that the work of the groups can proceed smoothly and members are kept informed. Members will be able to monitor the costs incurred via the annual financial statements.

This is an important change for BAPM but we see it as essential if the relevance of the organisation, both to its members and the wider perinatal community and indeed the public, is to continue to develop. Neither the structures nor processes described here are set in stone; they are merely the suggestion of the Executive.

One particular issue that we need to debate in detail is whether the method described above for appointing sub-committee convenors is appropriate or whether the membership would rather see another election.



The Executive

Over recent years we, as an organisation, have tinkered with the executive structure but have to date ignored some of the wider drivers for change. Therefore whilst we have had members representing Scotland and Ireland on the Executive for many years there has been no similar representation for Wales. The changes to the political system that have taken place mean that to continue with this situation is untenable. The longstanding arrangements regarding obstetric representation on EC now no longer make sense in an Association which is genuinely seeking to represent perinatal opinion. Therefore we plan to seek a further obstetric member for the EC and, providing we can boost the number of obstetricians who are members of BAPM, move as quickly as possible to a representative structure which is identical to that for neonatology. Finally, we all recognise the increasing role of a variety of non-medical personnel in perinatal care. Therefore we feel it is appropriate to have a non-medical member of the EC and, hopefully, with increasing numbers of non-medical BAPM members it will prove appropriate, with time, to expand their role on the executive.

Being Perinatal

Many people see BAPM as predominantly a neonatal organisation and, if one looks at the membership, this appears to be true. However there have been consistent efforts over many years to try and bring an "obstetric" balance. The fact that the obstetric element of our planned joint trainees day had to be cancelled for lack of interest demonstrated that we have not succeeded in being seen as perinatal. It seems essential that if we are to be taken seriously as a perinatal organisation we must try harder to address this problem by making sure that our "agenda" is more balanced. This will be an important message for the new sub-committees described above.

And finally

Firstly I just wanted to thank all the members who have responded to the various requests we have sent out in the past year. Secondly a huge thank you to Christine Cooper and Julia Wheal for not only their hard work but also commitment and drive which has been so important in keeping the Association moving forward.

BAPM Dataset Review

Following a decision at the AGM in 2002 a working group has been considering whether any changes needed to be made to the BAPM minimum dataset, first published in 1997.

Members of the group are :

Dr Andrew Lyon (chair)
Professor Kate Costeloe
Dr Ben Shaw
Dr Neena Modi
Dr James Moorcraft
Dr Jag Ahluwalia
Sue Broom – Neonatal Nurses Association

There have also been discussions with Mr Vernon Boston on behalf of the Paediatric Surgeons.

The original dataset was created to allow standardised annual reports to be produced. The Standards for Hospitals Providing Intensive and High Dependency Care, published in 2001, recommended that as well as producing an annual report:

- units should collect data that allowed them to monitor workloads and the results of practice and,
- units should be appraised against national criteria of service provision.

The latter of these recommendations is one of the drivers towards the central collection of standardised neonatal data (the BAPM Data Network project). The review of the dataset supports this other project.

The group agreed that some changes were needed but, if the dataset is to be reliable, any data item that is included must have an unambiguous definition. This means that some items that were part of the original dataset have now been excluded. It is also important to emphasise that the dataset is not to be restrictive and individual units or networks may collect additional data items to address specific local needs.

It was felt important to collect raw data that was easily validated. From this could be derived other data items such as level of care, days of ventilation etc. To do this it is recommended that all units develop a system for the daily collection of data from each baby. This will also allow the collection of daily staffing numbers which can be analysed against workload. It is appreciated that this recommendation will have resource implications for units who do not collect data in this way, but these are likely to be small. If we are to improve the quality of neonatal data both locally and nationally,

then this must be seen as an essential task in the care of the baby and must be funded appropriately.

The group has defined 3 subsets of data that make up the complete dataset:

- A 'static' dataset (items collected once only for each admission)
- A daily dataset
- A staffing dataset.

Also included is a list of items that are difficult to define unambiguously and therefore unsuitable for national pooling, but which may be collected within a unit or network using locally agreed definitions.

The first draft of the proposed dataset is available on the BAPM website to allow members to comment.

Andrew Lyon

Clinical Trials Group

This group was formed in 1994 to help develop and support multicentre randomised controlled trials in perinatal medicine. The BAPM PCTG committee is a sub-committee of the Executive of the BAPM and is subject to the constitution of the BAPM.

Membership

The membership of the PCTG committee comprises the President and the Secretary of the BAPM (ex officio), and up to seven elected members. Members of the BAPM can be co-opted by the group as required. Members currently serve for a period of three years and may be re-elected for a further three years.

The present membership of the committee is:

Peter Brocklehurst (Convenor)
David Field (ex-officio)
Malcolm Chiswick (ex-officio)
Jim Thornton
Rhona Hughes
Sara Kenyon
Mike Maresh
Kate Costeloe
Kathryn Beardsall
Khalid Haque

(contact details available at www.bapm.org/ctg/committee.htm)

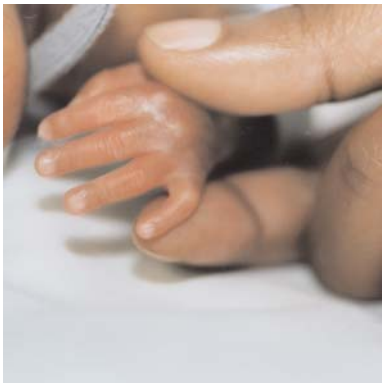
Mission

The current mission statement for this group is:

"To provide a forum for the development and conduct of high quality multi-centre research in the perinatal field."

The aim of the PCTG is to facilitate well-designed multi-centre research in the perinatal field, with a particular emphasis on randomised controlled trials, by:

- publishing a twice yearly newsletter on the BAPM website to provide information about multi-centre perinatal research requiring collaboration in the UK. This electronic newsletter currently contains up-to-date details of 20 trials recruiting or continuing follow-up in the UK (www.bapm.org/ctg/trials.htm).



- holding an annual meeting to promote the conduct of well designed multi-centre perinatal research. Topics included in the 2003 meeting included: Parental and professional views of perinatal pathology in the context of clinical trials; UK response to the EU Clinical Trials Directive; R&D funding in the NHS. In addition, five trials in development were discussed.

  Details of future meetings will be posted on the BAPM website (www.bapm.org/ctg). The next annual meeting will be on the 19 May 2004 in London.

- contributing to a register of ongoing, and planned trials.
- promoting well designed multi-centre perinatal research, as appropriate

The PCTG committee usually meets at least three times each year.

Peter Brocklehurst

Consent for examination and treatment of the newborn baby

Background

At the AGM in 2002 the attention of the membership was brought to a series of documents published by the DH in 2001 about consent for examination and treatment. The documents do not specifically address issues around neonatal practice. Some Trusts might interpret them to propose that explicit consent be gained more frequently than has been common heretofore and could conceivably obstruct good clinical practice.

Actions

At a subsequent meeting of the Executive Committee it was agreed that a Working Group should be convened by Kate Costeloe (membership: Jag Ahluwalia, Bryan Gill, Bonnie Green, Jane Hawdon, Shanit Marshall and James Moorcraft; further representation has been sought from the NNA and the ANNP group).

- 13 units of varying sizes, some with associated surgical units responded to a questionnaire about present practice and how BAPM might help.
- A single meeting of the Working Group was held on 04/07/03 at which it was decided that it would recommend to EC and the membership:
  - that the main thrust should be to give guidance to members and other professionals around the provision of consistent reliable information for families.
  - that two leaflets should be produced to inform staff of the ethical and legal framework around issues of consent with respect to Neonatal Medicine. The first should describe the legal background and the second give examples of good practice and recommendations as to when explicit consent should be obtained.
  - that BLISS should undertake a consultation amongst users addressing their experiences of agreeing procedures to be performed on their babies and of 'consent'.
  - that BAPM should develop a list of procedures for which it considers explicit consent should be gained.
  - that BAPM should produce agreed core information describing common procedures, drawing as far as possible on existing material, to be available on the website. This material should, whenever possible, be evidence based and include the objectives of the procedure and an estimate of risk.

- that this would help to avoid duplication of effort by staff in different Trusts developing similar material and should promote consistency of information.
- if these recommendations are supported by the EC and by the membership at the AGM, a programme of work will be developed. In addition we will notify the DH, who are due to review the present guidance later this year, of our plans.

Kate Costeloe

BAPM Data Network Project

The aim of this project, first discussed 3 years ago at the AGM in Bristol, is to develop an infrastructure to allow central collection of a standardised neonatal dataset.

Using web technology, software has been developed that can interface with existing clinical systems or allow data input if there is no current unit database. It is important to encourage audit data collection as part of normal care. The software allows both summary information to be entered as well as raw daily data, with the automatic production of user defined patient and unit summaries.

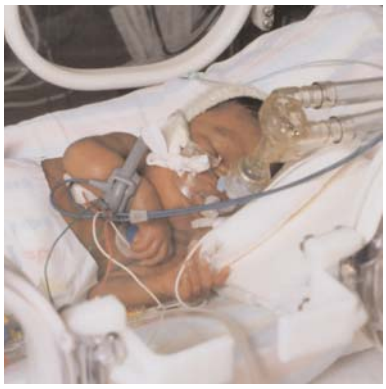
Within the system there are automatic links from the data to whatever other data collection projects the unit subscribes, such as BAPM, Vermont-Oxford etc. The software extracts, validates, anonymises, compresses, encrypts and sends data to a central source.

A central website, which will run on the NHS net, has been developed for the project. This will hold the pooled data. Users will be able to use specially designed analysis tools to interrogate the database and produce user defined reports.

Recruitment of units

10 sites were initially identified as part of a pilot funded by money from South East Region. 16 sites within London are now joining the pilot, and the software is currently being implemented.

Regional initiatives in the West Midlands, North West and South East of England have purchased the same software directly. They are using the same model for 'regional' data collection but are not part of the pilot project. All these units have agreed in principle that data can be made available to the national project.



Current position

The unit based software is being widely used for data collection. User testing has resulted in many refinements and 'bug fixes'. It is now a stable system. There have been delays and problems in implementation which are highlighted below.

The software has not been interfaced with any current system, although technically this is not a major problem in most cases. With some commercial systems there will be a significant cost associated with this exercise, although Clevermed do not charge for 'their side' of the interfacing exercise.

Central collection of data was due to start earlier this year but has been delayed while decisions are made about the BAPM minimum dataset. This is the subject of another report to the AGM. It is likely that the main outline of the revised dataset will be ready soon after the AGM. We can then configure the export module of the unit software and start recording data centrally. This exercise will include retrospective data.

Problems

As with all projects involving busy clinicians there has been an underestimation of the time that it would take to implement any of the stages. This is despite general enthusiasm about the importance of this project. Clevermed, the software company, have increased staffing to deal specifically with implementation issues. The project has been developed on limited funding and relies on busy people driving it forward. It will succeed but slowly unless further resources can be found to support the clinical implementation within the units.

There have been delays because of the 'confusion' that is IT in the NHS. There is no standardisation of technical platform and each Trust has its own problems, making implementation slower than expected. It is not only the technical aspects that vary, the 'political' will to help make this a success is not found in all Trust IT departments. There is wide variation in what individual Trusts will 'allow' to happen and often the reasons for the variation are not clear. Such wide variations are going to hamper any attempt to introduce any IT at a national level.

Issues around Data Protection still need to be addressed. The original idea was for anonymised data only but it is hoped that the use of the NHS number will allow linkage to other datasets as well as tracking babies who have care in a number of different units.

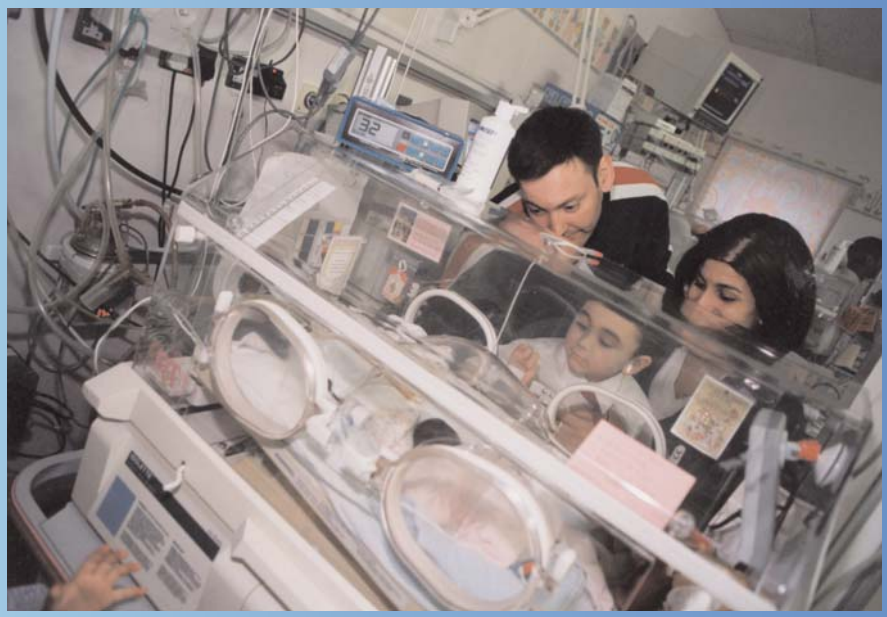
Funding for this project after the pilot has not yet been addressed. This will involve ongoing support for the unit software and the website as well as funding for data administrators, statistical expertise etc.

There was a meeting convened by the DoH policy branch on 3rd June 2003 to look at neonatal audit data collection. This was following the release for consultation of the DoH NIC review in which it was recommended that an

audit system be established. Commissioners and neonatal clinicians were invited to this meeting which reviewed the issues around data collection and reviewed what was happening at the moment. Confidentiality and data protection were raised as issues that need some guidance from DoH.

If we can drive this BAPM project forward over the next months and show that the model works, then the DoH may see this as the way forward for national neonatal data collection. This may have implications for the way this project is funded in the future.

Andrew Lyon



Financial Statements for the year ended 31 March 2003

Legal and Administrative Information

Charity Name:
British Association of Perinatal Medicine

Nature of Governing Document:
Deed of Trust establishing unincorporated charitable trust

Charity Number: 285357

Trustees:
Prof A Wilkinson, President (to Sept. 2002)
Prof M Chiswick, President (from Sept. 2002)
Prof D Field, Secretary
Dr D J Lloyd, Treasurer

Method of Appointment of Trustees:
The founding Trustees of the Charity have the power to appoint new Trustees. An amendment to the Deed of Trust in November 2001 appointed those individuals who hold the offices of President, Secretary and Treasurer of the Charity as Trustees.

Principal Office: 50 Hallam Street, London W1W 6DE

Independent Examiner:
Mr B Moran
Johnston Carmichael
Chartered Accountants and Business Advisers
Bishop's Court, 29 Albyn Place,
Aberdeen AB10 1YL

Bankers:
Bank of Scotland, 39 Albyn Place,
Aberdeen AB10 1YN

Report of the Trustees

The Trustees present their report with the financial statements of the Charity for the year ended 31 March 2003.

Principal Objective

The British Association of Perinatal Medicine was established in 1976. Its constitutional aim is to improve the standard of perinatal care in the British Isles. This has been done by defining standards of staffing, equipment and facilities and by preparing guidelines on good management of perinatal problems. The Charity is, in conjunction with the Royal College of Paediatrics and Child Health, responsible for defining the training of doctors in Perinatal Medicine. It also acts as a facilitator of research by the Perinatal Clinical Trials Group. In addition, it is a source of advice to government and other professional bodies on developing and improving perinatal care.

The activities of the Charity have increased considerably over the last 25 years and the Charity is now a major sub-speciality group of the Royal College of Paediatrics and Child Health.

Organisation

The Charity is administered by an Executive Committee with powers delegated from the Trustees in accordance with provisions included in the Deed of Trust.

Review of Activities

In the last 12 months the main activity of the Charity has been involved in answering submissions from the Department of Health and advising Government on various aspects of neonatal medicine by contributing to various committees. It has worked with the Royal College of Paediatrics and Child Health advising on the training of doctors within neonatal medicine and provided two scientific meetings to enhance postgraduate education. It has strengthened its links with other organisations involved in the care of the mother, fetus and newborn and has provided advice on research.

Reserves

The income from the subscriptions, non-specified donations and the annual general meeting is used to service the office accommodation, Administrator, working parties and the Executive Committee. The Trustees are satisfied that the level of unrestricted funds held are sufficient to meet the management and administration costs of the Charity.

As explained in the notes to the financial statements the Charity has restricted funds. The level of funds available in the Founders lecture fund is considered adequate to meet its purpose as set out in the notes to the financial statements. The Library fund is being accumulated in order to finance the establishment of a library of perinatal medicine to further the objectives of the Charity.

Major Risks

The Trustees have reviewed the major risks to which the Charity is exposed and have established systems to mitigate those risks.

Statement of Trustees' Responsibilities

Law applicable to Charities in England and Wales requires the Trustees to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year and of its 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 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, subject to any departures disclosed and explained in the financial statements;
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.

The Trustees are responsible for keeping accounting records which disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with The Charities Act 1993. They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Report of the Independent Examiner to the Trustees

I report on the accounts of the Charity for the year ended 31 March 2003.

This report is made solely to the Charity's Trustees, as a body. My work has been undertaken so that I might state to the Trustees those matters I am required to state to them in an Independent Examiner's Report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Charity and the Charity's Trustees as a body, for my work, for this report or for the opinions I have formed.

Respective Responsibilities of Trustees and Independent Examiner

The Charity's Trustees are responsible for the preparation of the accounts. The Charity's Trustees consider that an audit is not required for the year (under section 43(2) of the Charities Act 1993 (the 1993 Act) an that an independent examination is required. It is my responsibility to examine the accounts (under section 43(3)(a) of the 1993 Act; to follow the procedures laid down in the General Directions given by the Charity Commissioners (under section 43(7)(b) of the 1993 Act); and to state whether particular matters have come to my attention.

Basis of Independent Examiner's report

My examination was carried out in accordance with the General Directions given by the Charity Commissioners. An examination includes a review of the accounting records kept by the Charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as Trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently I do not express an audit opinion on the view given by the accounts.

Independent Examiner's Statement

In connection with my examination, no matter has come to my attention which gives me reasonable cause to believe that in any material respect the requirements to keep accounting records in accordance with section 41 of the Act and to prepare accounts which accord with the accounting records and to comply with the accounting requirements of the 1993 Act have not been met, or to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Mr B Moran
Johnston Carmichael
Chartered Accountants and
Business Advisers
Bishop's Court
29 Albyn Place
Aberdeen AB10 1YL

Statement of Financial Activities for the Year Ended 31 March 2003

	Note	Unrestricted Funds	Restricted Funds	Total Funds 31/03/03	Total Funds 31/03/02
Incoming Resources		£	£	£	£
Subscription and donations		52,504	-	52,504	40,447
Dunn donations		-	10,000	10,000	10,000
Annual General Meeting surplus		5,578	-	5,578	3,674
Sale of publications/membership list		385	-	385	792
Bank interest receivable		3,018	1,957	4,975	7,191
TOTAL INCOMING RESOURCES		61,485	11,957	73,442	62,104
Resources Expended					
Management and administration costs	4	52,354	-	52,354	38,345
Founders lecture fee		-	220	220	220
		(52,354)	(220)	(52,574)	(38,565)
NET INCOMING RESOURCES FOR YEAR		9,131	11,737	20,868	23,539
Funds Brought Forward at 1 April 2002		129,534	83,452	212,986	189,447
Funds Carried Forward at 31 March 2003		138,665	95,189	233,854	212,986

Balance as at 31 March 2003

	Note	31/03/03 £	31/03/02 £
Fixed Assets:			
Presidential badge (at cost)	6	1,000	1,000
Current Assets:			
Debtors	7	15,076	14,807
Bank - Dunn library fund		79,350	68,016
Bank - Founders lecture fund		15,295	15,005
Bank premier account		150,690	150,036
Bank current account		233	88
		260,644	247,952
Current Liabilities:			
Creditors: Amounts falling due within one year	8	(27,790)	(35,966)
Net Assets		£233,854	£212,986
Unrestricted Funds		138,665	129,534
Restricted Funds		95,189	83,452
Total Funds	9 & 10	£233,854	£212,986

Notes to the Financial Statements

1. Accounting Policies

Accounting Convention
The financial statements have been prepared under the historical cost convention and on the accruals basis.

Statement of Recommended Practice and the Financial Reporting Standard for Smaller Entities
The financial statements have been prepared in accordance with the Financial Reporting Standard for Smaller Entities (effective June 2002) and follow the recommendations in Accounting and Reporting by Charities: Statement of Recommended Practice issued October 2000.

Unrestricted funds
Unrestricted fund income is included as it becomes receivable and represents annual subscriptions and donations and other incoming resources receivable or generated for the objects of the Charity without further specified purpose and are available as general funds. Resources expended in the management and administration of the Charity are charged to the fund as they become payable. As the Charity is not VAT registered resources expended are stated inclusive of irrecoverable VAT.

Restricted funds
Restricted fund income is included as it becomes receivable and represents income to be used for the specific purpose laid down by the donor. Resources expended which meet the donor's criteria are charged to the fund as they become payable. As the Charity is not VAT registered resources expended are stated inclusive of irrecoverable VAT.

2. Trustees Expenses

The Charity reimbursed expenses of £741 (2002: £497) to Dr Lloyd, £655 (2002: £789) to Prof Wilkinson, £414 to Prof Field and £288 to Prof Chiswick during the year. No other expenses were paid to those who served as Trustees during the year.

3. Trustees Remuneration

No remuneration was paid to any of the Trustees during the current or the previous year.

4. Management and Administration Costs

	31/03/03 £	31/03/02 £
Office administration and accommodation costs	34,023	27,148
Meeting costs	6,464	4,008
Newsletter costs	3,169	672
Independent examiner's remuneration (see note 5)	2,233	2,938
Other	6,465	3,579
	52,354	38,345

5.Independent Examiners Remuneration

	31/03/03 £	31/03/02 £
Independent examiner's remuneration is as follows:		
Independent examination	588	588
Other financial services -		
- year ended 31/3/02	-	2,350
- year ended 31/3/03	1,645	-
	2,233	2,938

6. Tangible Fixed assets

	Presidential Badge £
COST:	
At 1 April 2002 and 31 March 2003	1,000
NET BOOK VALUE:	
At 31 March 2003	1,000
At 1 April 2002	1,000

No depreciation is provided on the Presidential Badge as, in the opinion, of the Trustees the value of the badge is not significantly different from cost.

7. Debtors: Amounts falling due within one year

	31/03/03 £	31/03/02 £
Subscriptions, etc.	925	6,229
Income tax recoverable	8,974	8,092
Prepayments	5,178	486
	15,076	14,807

8. Creditors: Amounts falling due within one year

	31/03/03 £	31/03/02 £
Accruals and returned subscriptions	27,790	35,966

9. Analysis of Net Assets between Funds

	Unrestricted funds £	Restricted funds £	Total funds £
Fixed assets	1,000	-	1,000
Current assets	165,455	95,189	260,644
Current liabilities	(27,790)	-	(27,790)
Net assets at 31 March 2003	138,665	95,189	233,854

10. Movements in Funds

	At 1/4/02 £	Incoming resources £	Outgoing resources £	Transfers £	At 31/3/03 £
Restricted funds:					
Dunn - Library fund	68,447	11,667	(-)	-	80,114
Dunn - Founders lecture fund	15,005	290	(220)	-	15,075
Total restricted funds	83,452	11,957	(220)	-	95,189
Unrestricted funds:					
General funds	129,534	61,485	(52,354)	-	138,665
Total funds	212,986	73,442	(52,574)	-	233,854

Purposes of restricted funds

Dunn - Library fund
This fund represents annual donations which are being accumulated by the Charity to eventually fund the establishment of a library of perinatal medicine to further the objectives of the Charity and be accessible to those individuals who are involved in the provision of perinatal care in the British Isles.

Dunn - Founders lecture fund
This fund represents donations which are used to remunerate the individual who performs the lecture at the Annual General Meeting of the Charity.

11. Controlling Parties

The Charity is controlled by the Trustees. The Trustees have delegated the administration of the Charity to an Executive Committee in accordance with the provisions of the Deed of Trust.

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