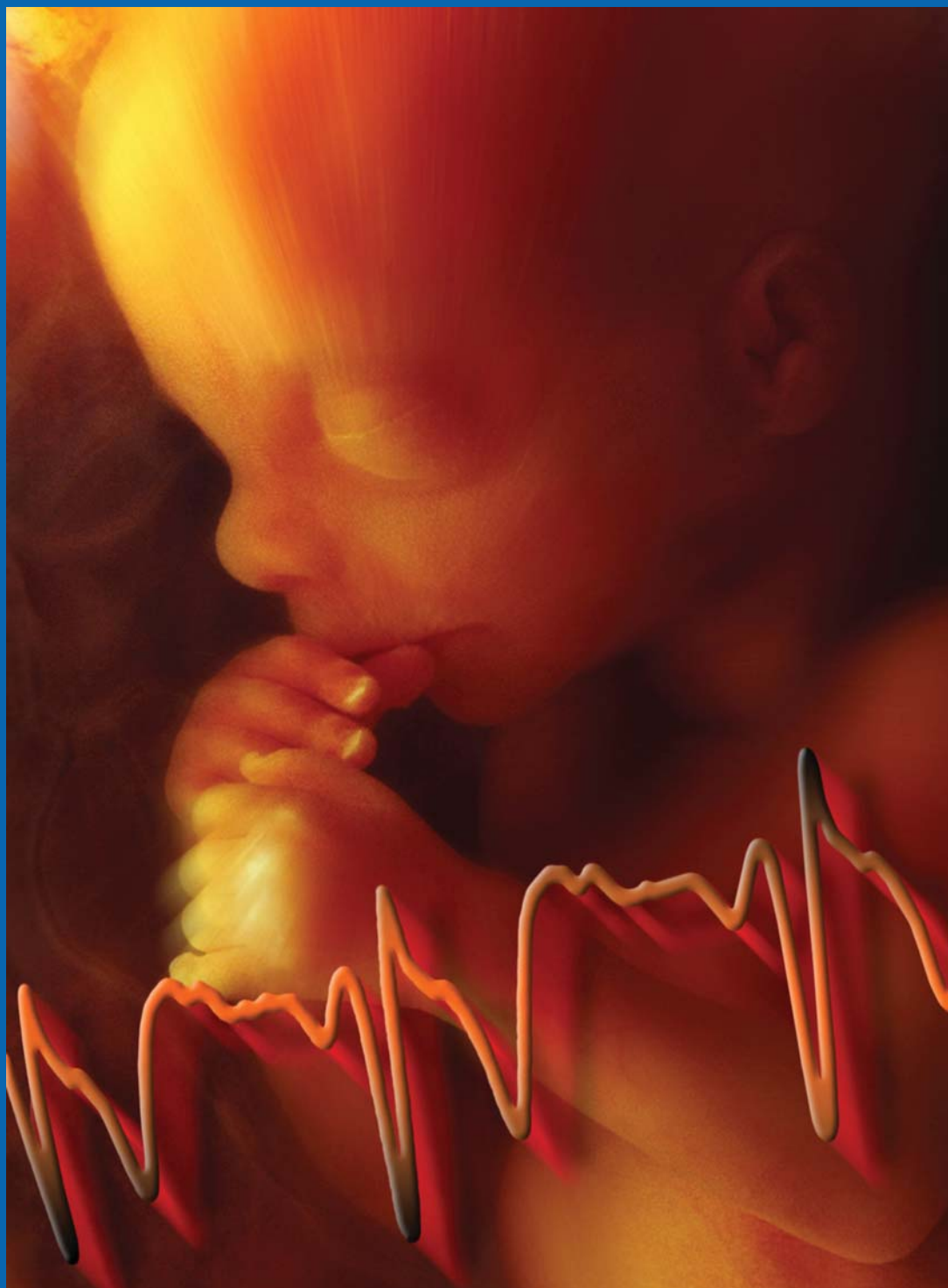
BRITISH ASSOCIATION OF PERINATAL MEDICINE

Founded 1976

Annual Report 2004



President's Introduction

This year's Annual Report coincides with the Annual General Meeting taking place in Manchester where it was previously held almost 25 years ago. The focus then for BAPM was the desperate shortage of neonatal intensive care facilities and nursing support to cope with growing advances in neonatal care, especially the widespread introduction of assisted ventilation.

The work of BAPM has become more complex and demanding over recent years in keeping with the well-established paradox that improved treatments and better outcomes bring additional challenges. In his report, our Honorary Secretary has nicely summarised how our organisation is responding to new clinical demands and to the sweeping changes that are occurring in the NHS.

The growth of other professional organisations whose interests overlap with BAPM should be viewed positively. Rather than re-focussing our interests to become a "neonatal organisation" we need to engage with other professional groups to further our key function which is to improve standards of perinatal care. To this end we will continue to encourage the multidisciplinary membership, and we will remain active across a range of functions including influencing national policies, setting standards for clinical care, supporting training and education, and encouraging multi-centre research.

As neonatal networks evolve we will need to keep our eye on commissioning arrangements across the regions especially if payment by tariff becomes widespread in the NHS. Our organisation must also be prepared for an increasing role in engaging with the public on ethical issues that will arise as a result of medical advances clustered around genetics, assisted reproduction, and fetal medicine and their impact on neonatal services.

On behalf of our members I wish to thank our Honorary Secretary, David Field, who has expertly guided BAPM through its many achievements during his term of office. On a personal level David has provided me with sound and thoughtful advice over many difficult BAPM issues.

Finally my thanks, as ever, to Christine Cooper and Julia Wheal for their expert administrative and organisational skills which have contributed so much to BAPM's achievements in the past year.

Honorary Secretary's report

In last year's report and at the AGM we focused a great deal on the future direction and structure of BAPM. A wide variety of opinions were expressed then and in subsequent meetings of the executive but the majority view was that BAPM should continue to pursue a truly perinatal and multidisciplinary agenda. Partly as a result of this decision and partly through changes in the NHS, this year has seen us move further down this path. Some of the important steps have been:

- The structure of the executive now reflects much more closely the broad make up of UK perinatal services and has wider geographical representation.
- We are using local meetings and e-mail to try and keep members closely in touch with relevant perinatal issues around the UK.
- BAPM now has more representatives on the relevant "National Committees" relating to perinatal issues than ever before.
- We are increasing our involvement in producing key guidelines / position statements in relation to perinatal care.
- We are developing a mechanism for sharing high level perinatal risk management information.
- We are more actively involved with training and trainees.
- There is now an increasingly close alliance with BLISS.

It is important to emphasise that this is not all that we do but these issues do reflect many of our key areas of current activity. A more longstanding role fulfilled by BAPM is to represent a professional view of perinatal care and perinatal issues in all of the relevant forums. In the current NHS it seems particularly important to maintain a high profile if problems and issues relevant to perinatal care are to be addressed. When the long awaited Children's and Maternity NSF is eventually published this will become even more important. I want to emphasise here how important I consider our relationship with BLISS in this regard. Although both organisations have a range of activities which are unrelated we do share a joint agenda in relation to raising the profile of perinatal care within the UK. Whilst BAPM does this from a professional point of view BLISS provides the more powerful family perspective. I hope our collaborations continue to flourish.

So where does that leave BAPM in terms of the medium term? My feeling is that slowly but surely we need to do more in order to maintain the professional / clinical profile of perinatal medicine and ensure that it receives the attention it deserves. However BAPM is its members. We rely on people giving their time to serve and contribute to various groups and this can be onerous both in terms of actually attending meetings and also taking seriously the process of consultation and feeding back. If we continue to develop our activities then inevitably we will involve more and more members

in an active fashion. Making this happen efficiently will not occur by chance. If we are to continue to raise our profile at some point additional staff will also be needed to underpin our efforts. Although the extra cost of doing this can be partially offset by new ventures (such as advertising on our website) it is inevitable that at some point subscriptions would need to rise. This trade off will be important for members to consider carefully when the time arrives.

In terms of the immediate future I see two logical steps for us to take. Both would involve formalising our work in a particular area by establishing sub-committees of the executive to oversee on going activity in each of the two areas:

1) Andy Lyon and colleagues have spent a long time reviewing the BAPM dataset and the revised version is now available. (Current developments in relation to the production of a national perinatal dataset have given new relevance to BAPMs long standing commitment to the production of a minimum dataset.) However we are aware that there are significant omissions in terms of items relevant to obstetric care and surgery. To remain relevant the dataset needs regular monitoring so that definitions can be refined, omissions dealt with and new issues incorporated on an on going basis - rather than changes made after ad hoc intervals. It seems sensible that the dataset group continues to "meet" in order to monitor these issues, providing regular feedback to the executive and the AGM. In most cases meetings of this group can take place by telephone conference.

2) The RDS guidelines are currently being reviewed. However this process began only some time after the last set had expired. Again it would seem sensible that our work in relation to guidelines and position statements is overseen by a group reviewing this area on a regular basis not simply when a document has clearly become out of date. The logical time to consider the establishment of such a group will arise in the next few months when the current review of the RDS guidelines (which I hope to continue to oversee to its conclusion) is complete.

   On the horizon, but not quite so pressing is the need to update our standards for both obstetric and neonatal care. Again a rolling programme of review would seem a sensible development to deal with this project in due course.

Finally, since my term of office ends at this AGM, I would like to thank all of the various colleagues with whom I have worked in the 10 years that I have been involved with the executive, the last three as Hon Sec. I would particularly like to thank Christine Cooper who took up her post when I became Secretary and who has made a huge contribution to the running of the Association and keeping my head mainly above water. It just remains for me to wish my successor, Andy Lyon, every success for the next three years.

Report from Scotland

Maternity and neonatal services are in the process of significant changes.

Consultant obstetric and paediatric units in some areas are changing to community midwife run units. As expected local populations are not happy with this downgrading of their delivery service and there is concern that planning is not co-ordinated nationally, but is organised on a local basis. Significant pressure on the smaller units comes from reduced working hours and increasing difficulty in providing staff to run the service.

NHS Greater Glasgow is currently planning to reduce the number of neonatal intensive care units in the city from 3 to 2. NHSGG have suggested that as part of this re-organisation the Queen Mother's Hospital on the Yorkhill site should close. Neonatologists in Scotland oppose this plan as QMH is co-located with the Royal Hospital for Sick Children and provides specialist services for neonatal patients. Some of these services such as neonatal cardiology/cardiac surgery are national services and changes will affect neonates from all Scottish regions. This plan would also separate the Ian Donald Fetal Medicine Department (the national fetal medicine centre) from the children's hospital. NHSGG are concerned that QMH is not co-located with an adult hospital. Currently Malcolm Chisholm the Scottish health minister is studying the NHSGG plan.

There is a proposal to develop Maternity Regional Planning Groups, which will hopefully lead to an improvement in the provision of services to Scotland.

The Scottish neonatal transport service is now well established. It is organised on a regional basis with 3 separate teams in Glasgow, Edinburgh and Dundee/Aberdeen. The west of Scotland team carried out 632 transfers between June 2003 and 2004, an average of 1.7 per day. 192 were emergency transfers (usually into a regional centre) with 440 elective transfers.

The 5 Scottish centres for neonatal training (Yorkhill, Princess Royal, Simpson, Dundee and Aberdeen) are in the process of putting a training scheme together for the neonatal training grid.

The Scottish Neonatal Consultants Group remains active with 4 meetings per year. An educational day is planned for later in the year.

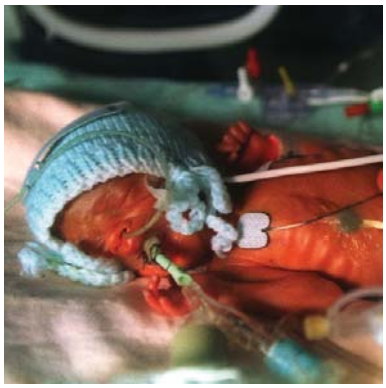
Jonathan Coutts

Representative:
Dr Jonathan Coutts
Glasgow Maternity Hospital

Deputy Representative:
Dr William McGuire
Ninewells Hospital, Dundee

Obstetric Representative:
Dr Rhona Hughes, Royal Infirmary of Edinburgh

Report from Wales



Welsh Assembly Government

Following devolution all health issues in Wales have been entirely devolved to the Welsh Assembly Government. There is a separate Minister for Health and Social Services, Mrs Jane Hutt, who reports to the First Minister, Mr Rhodri Morgan and the National Assembly. There is an independent Health Division within the National Assembly and Wales has it's own Chief Medical Officer, Dr Ruth Hall. Health policy in Wales differs from that in England and Government has independent managerial and financial structures within Wales. Decisions on health investment and on determination of priority areas for development are made in Wales to a Welsh agenda.

Current Status

Wales currently has 22 local health boards and 13 NHS Trusts with maternity services. These are overseen by 3 regional offices representing South and East Wales, Mid and West Wales and North Wales. The neonatal services are widely dispersed with informal networking attempting to overcome the difficulties associated with capacity, staffing and access issues. There is a widespread recognised need to modernise and re-organise the maternity and neonatal services. The Welsh Paediatric Society has a Welsh Neonatal Sub Committee which is linked to the "All Wales Neonatal Network". Monthly meetings alternate between business/network development issues and educational meetings. In general these are attended by neonatal paediatricians and neonatal nurses as well as representatives from the national reviewing bodies. There is currently no regular involvement of obstetricians. Once each year there is a joint meeting with the South West Region. Also once each year there is an all day neonatal seminar at the University Hospital of Wales in Cardiff.

Reviews in Progress

There is a review of neonatal care for Wales by the Specialist Commissioners "Health Commission Wales". This review has an external Chair, Professor Andrew Wilkinson, Professor of Paediatrics at the University of Oxford. This review is running in parallel with the Children and Young People Specialised Services project (CYPSSP) led by the Chief Medical Officer working towards the Children's NSF for Wales. In the background there has been the "Wanless" Report for Wales. It's overall conclusion was that generally the healthcare position in Wales is worse than in the UK as a whole and that the current position is not sustainable. A whole system reconfiguration of the NHS in Wales is needed. As one of the responses to the Wanless Report, the Maternity Professional Advisory Group has been established. This group includes membership from Wales of obstetricians, neonatal paediatricians, anaesthetists, midwives and professionals with interests in education together with officials from Welsh Assembly

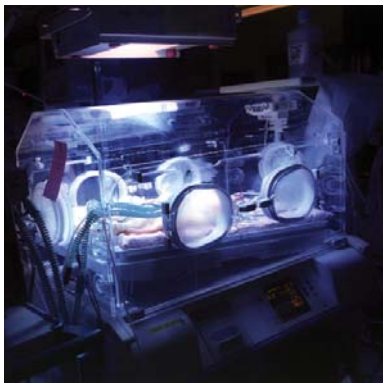
Government and external advisors from outside Wales. This group is established to advise the Minister for Health and Social Services on a new blueprint for maternity services taking account of current external factors and sustainability. Clearly this group considering the future number and location of midwifery led units and consultant led maternity units will need to work very closely with the other neonatal and children' services reviews.

James Moorcraft

Representative:
Dr James Moorcraft
Royal Glamorgan Hospital, Llantrisant

Deputy Representative:
Dr Patrick Cartlidge
University of Wales College of Medicine, Cardiff

Report from Ireland



The current representatives took up office following the resignation of Prof. Tom Matthews due to work pressures.

There is a small membership both North and South of the border made up of mainly neonatologists and obstetricians, but we hope to invite other professionals to join the BAPM in the coming years.

There have been a number of important events in the past year, not least of which was the final decision by the Department of Health to site the proposed new Belfast Maternity Hospital on the Royal Group of Hospitals site, and we are now in the planning stages.

Work is also progressing towards setting up a Northern Ireland regional neonatal/paediatric transport service and it is hoped that the neonatal component of this might be operational on a limited basis by next year. There is already a neonatal retrieval service in the South of Ireland and there may be scope for collaboration between the two.

An informal neonatal network has existed in Northern Ireland for many years but we are working to strengthen this with regular multi-professional meetings and by producing regional guidelines and other activities. A web-based cot availability service is being developed.

We are also in the process of setting up a North-South training rotation for higher specialist training in neonatal medicine, with a year spent in each of the regional units.

The 2005 AGM will be held in Belfast and we look forward to meeting you all again there!

Richard Tubman

Representative:
Dr Richard Tubman
Royal Maternity Hospital Belfast

Deputy Representative:
Dr David Corcoran
Rotunda Maternity Hospital, Dublin

Report: South of England

While within our own hospitals a large proportion of energy has been expended finding ways to comply with the European Working Time Directive and trying to find competent staff to fill the non-training posts that we're forced to create simply to keep the show on the road, on the more public front the talk has been of networks.

BAPM has been keen to increase its accountability to the membership so that people have the opportunity to contribute throughout the year rather than simply at the AGM. One way to achieve this is by increasing the local accountability of the "Regional Representatives" to their constituents. In May 2003 a meeting was held attended by a small group of paediatricians and obstetricians who in some sense represented perinatal activity in their patch across the South of England. Their wide-ranging discussion was distilled into a list of recommendations presented to the Executive Committee and circulated with the papers for last year's AGM.

This year, rather than simply repeat that process, it was proposed that those people re-convene in the morning to review progress on their recommendations and that in the afternoon we have a more open meeting focussed on progress with networks. In the event there was little enthusiasm for the morning, but in the afternoon 38 people gathered together with representatives from all 14 networks in the South of England together with colleagues from South Wales with additional input from BLISS, Public Health and from commissioners.

The time was mostly spent in workshops and a number of important points came through:

- The importance of getting the perinatal services identified as a priority on the PCT agenda through inclusion in their development plans (LHDPs).
- The importance of having strong links into local groups such as MSLCs and PALs that can provide support.
- The importance of providing clear information to the public so that they understand the basis for any recommended service change.
- That the use of the terms Intensive, High Dependency or Special Care Cot as a currency should be used with caution. We should distinguish between cots which are historically described as "funded" which are often not fully equipped and staffed and those which can be shown to be appropriately equipped and staffed to BAPM standards.
- The increasing importance of the role of the Strategic Health Authorities in performance managing PCTs.
- The need for clarification of commissioning arrangements for surgical services.
- The point that was strongly made in the 'National Review', that a baby's

needs are defined by its dependency and not by where it is; i.e. that a baby that needs intensive care has the same requirements in terms of the skills of the responsible professionals and the infrastructure whether the unit it's in is nominally a Level 2 or 3 unit.

It was clear in discussion and from the results of a questionnaire completed by 29 people present that progress is variable. 11 of the 14 networks had identified their perinatal centres, 10 had an operational network board and all of these had appointed Clinical Leads, these were all paediatricians and 7 were from perinatal centres. Only 4 networks had appointed a Lead Nurse and 6 had Managers. When asked to rate on a scale of 1 to 10 how confident people were that the new money available was being used appropriately to increase access to staffed intensive care cots, the median response for the capital was 7 with an interquartile range of 5 to 7.5 and for the revenue, 5 with an interquartile range of 3.5 to 8. A large majority reported finding the afternoon useful and all felt that such sessions should be repeated with an increased emphasis on operational rather than strategic issues on at least an annual and possibly a 6 monthly basis.

Specific recommendations to the Executive Committee included the view that the association should be taking a lead defining models of networks and templates for commissioning arrangements and that it should hold a repository of papers such as network Terms of Reference and Job Descriptions.

Although we had apologies from others who were keen to come, the meeting was attended by only one obstetrician; we need to increase engagement of obstetric colleagues and there was a view that we should be trying to do this through hospital fetal medicine departments.

There is clearly a hunger amongst staff for sessions such as this. It was not expensive to organise as we offered no expenses and provided just very basic food. Similar gatherings would probably be helpful over the next few years as we face a range of challenges.

I stand down at this year's AGM at the end of my 3 year period as South of England Representative, it has been great fun and I would particularly like to thank Christine Cooper for all the help she has given me. Mike Hall takes over from me and will be supported by a new Deputy who will be elected soon. I wish them both well.

Kate Costeloe

Representative: Prof Kate Costeloe, Homerton University Hospital, London
Deputy Representative: Dr Michael Hall, Princess Anne Hospital, Southampton

Obstetric Representative: Dr Donald Peebles, UCLH
Deputy Obstetric Representative: Ms Katharine Stanley, Norfolk & Norwich

Report: North of England

Representatives of a number of networks for the northern constituency of BAPM met in March of this year to discuss the role of BAPM within emerging networks. It was generally felt that it had been a useful meeting and that BAPM was in a good position to be able to provide support for the networks, particularly in relation to standards, providing a forum for best practice and possibly a common research forum. Members were also keen that BAPM continue to try and exert influence over the Government on key issues and that stronger links should occur with BLISS. It was strongly felt that BAPM's direction and role could be facilitated by improved communication, for example via network leads and an improved website, but also that communication and links should be improved with other organisations such as the RCOG and the Neonatal Nurses Association.

The afternoon of the meeting was dedicated towards hearing how networks were evolving in each of the regions within the northern constituency. Different models of working were discussed. Points of best practice that were identified were that networks should be commissioner driven, have defined clinical lead roles, have funded support and should work within a team with IT support. It was felt that a designated manager was important and that decisions should be made by a network board, so that ownership and accountability was evident. Areas for networks to concentrate on included guidelines, education, best practice and transport. Some problems that were identified with emerging networks were lack of funding, lack of transport systems, parochialisation and non co-operation, difficulties with future proofing, over expectations, poor communication and difficulty with appropriate obstetric involvement. Finally, some other problems were identified in relation to variable terminologies being used to designate units, variability in outcomes being measured and the use of common data sets.

It is hoped to have another meeting in the Spring in between annual BAPM meetings to further share ideas and feedback to the Executive Committee.

Nigel (Ben) Shaw

Representative:
Dr Nigel (Ben) Shaw
Liverpool Women's Hospital

Deputy Representative:
Dr Alan Fenton
Royal Victoria Infirmary, Newcastle upon Tyne

Obstetric Representative:
Mr Peter Thompson
Birmingham Women's Hospital

Deputy Obstetric Representative:
Mr William Martin
Birmingham Women's Hospital

Report: Nursing/Midwifery

I'm really pleased to be able to provide the first report to the BAPM membership from the nursing and midwifery representative. This is a new position on the executive committee, agreed at the 2003 AGM and elected in 2004. These are early days in the development of a role which should become a significant contributor to BAPM activities and to perinatal care.

The nursing and midwifery membership of BAPM have responded positively and constructively to the new role, and have enthusiastically raised topics of concern which overlap with BAPM interests.

A feature of this new BAPM role is a joint nursing/midwifery remit. The first two holders of the post are both from neonatal backgrounds, and more robust mechanisms for capturing midwifery concerns for BAPM are needed, and are being developed. The issue of midwifery drills for neonatal resuscitation at home births has been raised, and requires further exploration.

For many neonatal units the provision of a skilled nursing workforce in appropriate numbers remains the element which defines unit activity. Many initiatives which involve working in new ways are in place around the country to attempt to keep services running optimally. These include flexible working and using non-nursing staff to undertake duties previously performed by nurses. There may be a need for best practice to be shared and adopted more widely.

The formation of a national network of research-active neonatal nurses has begun this year, under the auspices of BLISS and NPEU, and may help the development of an academic infrastructure in neonatal nursing.

The evolving process of organising into neonatal managed clinical networks is requiring the committed support of nurses through a period of potentially significant change and nurses are taking important roles in network decision-making.

The ANNP.uk group held a second excellent conference earlier this year, with high quality research and other presentations. The principal concern for ANNPs continues to be in the framework for drug initiation and administration. Many neonatal units are dependent for service delivery on ANNPs working outside of the legal framework, and this is clearly unacceptable. ANNP.uk is grateful for the continuing support of BAPM, both in the search for a practical and legal solution to this specific problem, and in other ways including the ANNP section of the BAPM website.

Andrew Leslie

Representative:
Dr Andrew Leslie
ANNP/Neonatal Transport Co-ordinator
Nottingham Neonatal Service

Deputy Representative:
Ms Alison Gibbs
ANNP, Queen's Medical Centre
Nottingham

Report: Allied Professions

This year has seen the introduction of a representative from the professions allied to medicine onto the BAPM committee. This marks the commitment of BAPM to holistic care for sick neonates and it is hoped will ultimately help to improve the care given on neonatal units across the UK.

This development occurs at a time of increasing internal organisation of some of these professions; their aim to provide practitioners with the appropriate specialist skills to work with sick and premature neonates.

In the UK the provision of care from allied professions such as physiotherapy, speech therapy and dietetic help has been sparse; however there appears to be an increasing demand for these services with more posts being created. Single handed therapists have been largely self educated with little or no peer review or formal training available. This situation is unsatisfactory and to remedy it the acquisition of highly specialised knowledge and skills should be available in recognised post graduate courses.

To address these inadequacies over recent years both physiotherapists and dietitians have established national interest groups. These have provided support for single handed practitioners, information exchange and the development of training programmes. Future plans include the development of competencies and bench marks by which to ensure safe and consistent care. In addition the formation of national groups will enable the opportunity to audit practice over a large number of neonatal units.

The establishment of links between these groups and BAPM promises benefits to both. It is hoped that the ensuing collaboration will help streamline approaches to problems common to all professions.

A great opportunity has arisen with the development of Neonatal Networks particularly if they can become a means to help communication between therapists within a defined geographical area. It is hoped that standards of care can be set and maintained locally with feed back to national interest groups. Small groups such as the allied professions need to work closely with their medical and nursing colleagues, neonatal networks may be a key mechanism by which to promote this.

Caroline King

Representative:
Caroline King Chief Dietitian Paediatrics
Hammersmith Hospital London

Deputy Representative:
Mr Simon Brake
Lead Commissioning Manager
West Midlands Specialist Services Agency

Parent's representative report

You can't move far in neonatology these days before you encounter a parent. Not only are they present on the unit, they are invited onto network planning boards, represented on neonatal reviews, interviewed at length for academic studies on the parents' experience. And take a look around the table at the BAPM Executive Committee meeting. Who is the new face at the end? Why, it's a parent representative of course - in this case the Chief Executive of BLISS who now attends as an observer.

Other recent and upcoming contributions of parents into neonatal decision making include:

Retinopathy of Prematurity

As BAPM prepares to updates it's guidelines for the screening and treatment of ROP it is setting up a steering group which will include patient representation. BLISS has found a willing parent who is ready to play her part.

Consultation on Consent

Parent input has been incorporated into the draft BAPM guidelines for seeking parental consent and will help to inform parents of the importance of their consent by inserting new an explanation of the guidance into our Parent Information Guide.

More parents asked to join network planning and advisory committees

BLISS has received many requests this year from network boards looking for parent representatives to join their number. We have been working to identify and recruit parents for these roles and make sure that they are properly supported. This includes developing guidelines for parents on how the system works. We also plan to put parent representatives in touch with each other so that they can share their experiences and help each other to make their contributions as relevant and effective as possible.

Parents helping to frame national policies

The Department of Health neo-natal review in England sought out the views of parents and parents groups, although the level of attention paid to their specific concerns in the review document itself was disappointing. A similar exercise now underway in Wales has planned for parent representatives to be on the review committee and it will be interesting to see whether this step will result in a more central place for parents needs in the Welsh policy analysis.

Parents as indicators of quality of care

The Healthcare Commission's framework for developing the neonatal clinical audit programme stresses the importance of measuring the parent's experience and using it as a contribution to understanding the quality of care their babies are receiving. Parents experiences may be explicitly included in the data to be collected within the neonatal audit.

Parents as providers of care

It's hard to tell but we feel that there is an increasingly view that parents can make a substantial (as opposed to marginal) contribution to the clinical outcome of a baby in intensive care. How far does your own unit subscribe to this view? Do you encourage kangaroo care (for which the evidence base is sometimes questioned) or do you simply tolerate it?

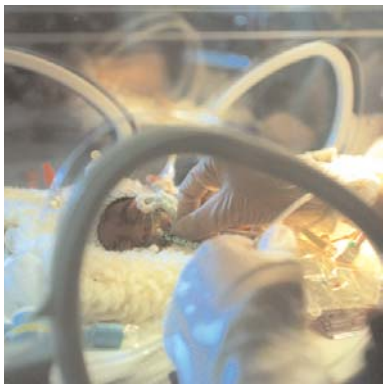
To what degree are parents clients?

This last point raises an issue I have puzzled over during the last twelve months. When neonatal clinicians, who may be sceptical about Kangaroo Care, continue to encourage parents to take their babies onto their chests, are they doing this primary because they can see the benefits of Kangaroo Care for the parents?

In the future will we judge a unit by the value added to parents as well as the value added to babies? Are we moving to a situation where we see the 'output' of a neonatal unit as not simply a number of babies in good health but also a set of parents who are as skilled and confident as they can be in caring for their babies? If the neonatal audit begins to measure the value added to parents on a reasonably comparative basis, then this broader view of the expectations of a neonatal unit will come a step closer. This is not an entirely novel idea but - if we follow the logic - it does have implications for how high up the priority list we put parents' accommodation and facilities when considering three year spending plans.

Rob Williams
Chief Executive Officer, BLISS

Consent for examination and treatment of the newborn baby



The preliminary proposals of this working group were presented to the AGM in September 2003 when it was agreed that:

- A leaflet should be produced for use by professionals summarising the framework for obtaining consent for examination and treatment
- That, in consultation with the membership, we should agree procedures for which we would recommend explicit consent be gained and those for which we would recommend that that consent was accompanied by a signature
- That we should not take forward the group's original recommendation that they should undertake a programme of work to agree core material summarising the objectives and the risks of all common procedures to be included in information given to parents

Two telephone conferences have been held since the last AGM and a great deal of correspondence has taken place by email.

In June a draft leaflet was placed on the BAPM website together with lists of common procedures with a recommendation as to the method of consent to be sought. The documents have been reviewed and amended as a result of the comments received and new versions are now available on the website. Comments are again invited but it is hoped that these can be endorsed at this year's AGM.

The group has two further recommendations:

1. That we produce a similar leaflet specifically for parents; a draft will be placed on the website prior to this year's AGM
2. That we develop agreed core material that should be included when consent is being obtained for those procedures for which we would recommend that it be explicit. This will be discussed at the Executive Meeting prior to the AGM.

Kate Costeloe

Working group members:

Kate Costeloe - Convener
Jag Ahluwalia - Neonatologist
Bryan Gill - Neonatologist
Bonnie Green - BLISS
Jane Hawdon - Neonatologist
Shanit Marshall - BLISS
James Moorcraft - Neonatologist
Lynne Paterson - Representing the *ANNP.uk* group
Tilly Reid - Representing the Neonatal Nurses Association

Financial Statements for the year ended 31 March 2004

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 M Chiswick, President
Prof D Field, Secretary
Dr D J Lloyd, Treasurer (to Sept. 2003)
Dr J Ahluwalia, Treasurer (from Sept. 2003)

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 G McDonald FCCA
Johnston Carmichael
Chartered Accountants and Business Advisers
Bishop's Court, 29 Albyn Place,
Aberdeen AB10 1YL

Bankers:

HSBC, 117 Great Portland Street, London W1W 6QJ
Bank of Scotland, 39 Albyn Place, Aberdeen AB10 1YN
Standard Life Bank

Report of the Trustees

The Trustees present their report with the financial statements of the Charity for the year ended 31 March 2004.

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

The last 12 months has seen the Charity continue to be involved in answering submissions from the Department of Health, as well as in advising Government on various aspects of neonatal medicine. The Charity remains involved in providing advice to the Royal College of Paediatrics and Child Health on aspects of training doctors within neonatal medicine. Postgraduate education has been further supported by the provision of scientific meetings, including a meeting targeted at trainees in perinatal medicine. A number of working parties have been established to develop guidelines, standards and recommendations on important aspects within perinatal medicine, including the management of respiratory disorders in pre-term infants, issues relating to gaining consent within neonatal practice, the design of neonatal intensive care units and the development of neonatal data sets. Links with other organisations involved in the care of the mother, fetus and newborn, continue to grow and this is reflected in the Charity's broader membership.

Reserves

The income from 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 which 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 2004, which are set out on pages 5 to 9.

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 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts (under section 43(3)(a) of the 1993 Act);
- follow the procedures laid down in the General Directions given by the Charity Commissioners (under section 43(7)(b) of the 1993 Act); and
- 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:

1. 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 1993 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
2. 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 2004

	Note	Unrestricted Funds	Restricted Funds	Total Funds 31/03/04	Total Funds 31/03/03
Incoming Resources		£	£	£	£
Subscriptions and donations		58,996	-	58,996	52,504
Dunn donations		-	10,000	10,000	10,000
Annual General Meeting surplus		2,264	-	2,264	5,578
Course/membership list income		923	-	923	385
CTG meeting income		1,550	-	1,550	-
Trainees meeting income		5,490	-	5,490	-
Bank interest receivable		2,344	2,818	5,162	4,975
Total Incoming Resources		71,567	12,818	84,385	73,442
Resources Expended					
Management and administration costs	4	75,738	-	75,738	52,354
CTG meeting costs		2,266	-	2,266	-
Trainees meeting costs		4,582	-	4,582	-
Founders lecture fee		-	320	320	220
		(82,586)	(320)	(82,906)	(52,574)
Net Incoming Resources for Year		(11,019)	12,498	1,479	20,868
Funds brought forward at 1 April 2003		138,665	95,189	233,854	212,986
Funds carried forward at 31 March 2004		127,646	107,687	235,333	233,854

Balance as at 31 March 2004

	Note	31/03/04 £	31/03/03 £
Fixed Assets:			
Presidential badge (at cost)	6	1,000	1,000
Current Assets:			
Debtors	7	21,495	15,076
Bank of Scotland - Dunn library fund		-	79,350
Standard Life Bank - Dunn library fund		90,000	-
Standard Life Bank - Dunn library fund		724	-
Bank of Scotland - Founders lecture fund		-	15,295
Standard Life Bank - Founders lecture fund		15,000	-
Standard Life Bank - Founders lecture fund		224	-
Bank of Scotland - Premier bonus		48,743	150,690
Standard Life Bank - Premium notice		85,711	-
Bank of Scotland - Treasurer		2,522	233
HSBC - Business money manager		3,950	-
HSBC - Treasurer		3,364	-
		271,733	260,644
Current Liabilities:			
Creditors: Amounts falling due within one year	8	(37,400)	(27,790)
Net Assets		**£235,333**	**£233,854**
Unrestricted Funds		127,646	138,665
Restricted Funds		107,687	95,189
Total Funds	9 & 10	**£235,333**	**£233,854**

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 comply with the Charities Act 1993 and 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 £4 (2003: £741) to Dr Lloyd, £190 to Dr Ahluwalia, £496 (2003: £414) to Prof Field, and £386 (2003: £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

	31/03/04	31/03/03
	£	£
Office administration and accommodation costs	50,231	34,023
Meeting costs	5,955	6,464
Newsletter costs	2,207	3,169
Independent examiner's remuneration (see note 5)	2,644	2,233
Other	14,701	6,465
	75,738	52,354

5. Independent Examiner's Remuneration

	31/03/04	31/03/03
Independent examiner's remuneration is as follows:	£	£
Independent examination	705	588
Other financial services -		
- year ended 31/3/03	-	1,645
- year ended 31/3/04	1,939	-
	2,644	2,233

6. Tangible Fixed Assets

		PresidentialBadge
		£
Cost:		
	At 1 April 2003 and 31 March 2004	1,000
Net Book Value:		
	At 31 March 2004	1,000
	At 1 April 2003	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 ferent from cost.

7. Debtors: Amounts falling due within one year

	31/03/04	31/03/03
	£	£
Subscriptions, etc.	3,205	925
Income tax recoverable	9,449	8,974
Prepayments and accrued income	8,841	5,177
	21,495	15,076

8. Creditors: Amounts falling due within one year

	31/03/04	31/03/03
	£	£
Accruals	37,400	27,790

9. Analysis of net assets between funds

	Unrestricted funds	Restricted funds	Total funds
	£	£	£
Fixed assets	1,000	-	1,000
Current assets	164,046	107,687	271,733
Current liabilities	(37,400)	-	(37,400)
Net assets at 31 March 2004	127,646	107,687	235,333

10. Movements in funds

	At 1/4/03	Incoming resources	Outgoing resources	At 31/3/04
	£	£	£	£
Restricted funds:				
Dunn - Library fund	80,114	12,489	-	92,603
Dunn - Founders lecture fund	15,075	329	(320)	15,084
Total restricted funds	95,189	12,818	(320)	107,687
Unrestricted funds:				
General funds	138,665	71,567	(82,586)	127,646
Total funds	233,854	84,385	(82,906)	235,333

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.

British Association of Perinatal Medicine
50 Hallam Street London W1W 6DE
Tel: 020 7307 5627
Fax: 020 7307 5627
Email: bapm@rcpch.ac.uk
Website: www.bapm.org

Charity No. 285357