BRITISH ASSOCIATION OF PERINATAL MEDICINE

Founded 1976

Annual Report 2005

President's Introduction

As this is my last AGM as President I want to reflect on some developments in perinatal medicine that have occurred since our organisation was founded in 1976. BAPM was born against a backdrop of decades of excellent perinatal research, with notable British contributions to fetal and neonatal physiology, but with little evidence of widespread translation of research into clinical practice. A step-wise increase in neonatal nursing staff and intensive care cots, backed up by education and training was needed, and BAPM's focus in its first ten years was to achieve this through a range of recommendations, including clarification of categories of neonatal care. Those politicians who viewed this activity as "shroud waving", failed to grasp the point that if there were no shrouds there would be nothing to wave.

Things have moved on a pace, and, thanks largely to our organisation, the evolving neonatal networks hold the promise of meeting the needs of newborn infants in a more structured way. It is now up to us as individual members to ensure that our work to get us to the current position during the last 30 years really does "improve the standard of perinatal care in the British Isles" – which is our mission statement. If we are to achieve this we need to engage and work with a range of professionals within the neonatal networks. For example, we must ensure that there is appropriate social service and community team support for those babies who are discharged home with special needs and for their families; that a move towards community-based or home deliveries is safely managed; that neonatal networks map to 24-hour paediatric units for those infants with continuing risks; and that the neonatal networks have available to them prompt advice from paediatric surgeons when needed.

The spread of neonatal intensive care across maternity units in the 1970's brought home to everyone how this was not a "ward-round" specialty, but was extremely work-intensive and required a huge commitment especially on the part of our nurses and junior doctors. That commitment is still evident now of course but the context has changed with neonatal nurses taking on new and broader roles, and the working time directive governing the hours of doctors in training. Many issues remain but the one on my mind is the need to ensure that the education and training doctors receive for a career in neonatology matches the demands that will be made on them as a consultants. These demands include burgeoning ethical issues, the rights and responsibilities of parents, communication skills, the limits of evidence-based medicine, managing clinical risks, and the need to achieve the right balance between the service, personal aspirations, and the objectives of the NHS Trust.

Finally – a word about the evolving interface of fetal medicine and neonatology. Fetal medicine, of course, did not exist as a sub-specialty when BAPM was founded. Arguably, it was the introduction of neonatal intensive care and an associated improvement in the survival of preterm infants that

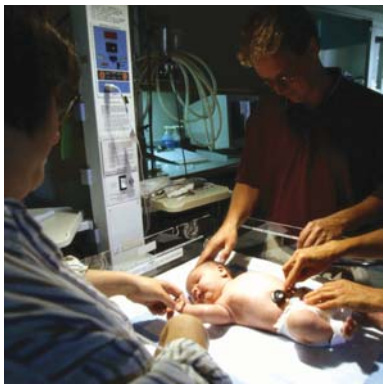
drove developments in fetal medicine – especially better methods of fetal assessment.

Emerging from the clinical concept of biophysical profiling there evolved a plethora of tests aimed at assessing fetal health and the timing of delivery of the compromised fetus so that the balance of risk might be weighted towards survival of a healthy infant. The core pathology I have in mind here is the interplay of the placenta and blood flow indices, fetal growth, and fetal hypoxia. A huge amount of epidemiological and clinical research is still needed, however, to fill the gaps between fetal assessment, antenatal intervention, and long term growth and development. At present it seems that we have the investigative tools but we're not entirely sure what to make of them.

Much the same can be said for the intrapartum assessment of fetal asphyxia. Although its contribution to the overall prevalence of disability in childhood may be relatively small, the implications for the affected child and family are disproportionately great. Against a background of competing needs in the NHS, which investment would yield a better result - improved training and organisation of midwifery and obstetric staff on labour wards so that existing protocols are followed? Or would you invest in ways of more accurately assessing asphyxia, including perhaps by computer-aided decision making? If the only justification for the word "perinatal" in our organisation is to probe and raise these sort of questions across the interface of fetal and neonatal medicine then that is reason enough.

It has been an exciting and rewarding three years for me and I thank everyone for their support.

Honorary Secretary's report



It has been an interesting year getting to grips with the workings of BAPM. This has been made easy by the efficiency of my predecessor, Professor David Field, and by the excellent work done in the office by Christine Cooper and Julia Wheal. Without them the current work of BAPM could not continue. Christine in particular has been responsible for stimulating the Association to look forward and review its aims and ways of working.

Over the years BAPM as an organisation has become increasingly important as a standard bearer for perinatal opinion. The published standards for hospitals involved in neonatal intensive and high dependency care have been widely used in the development of neonatal networks. It is important that we share the experiences, both good and bad, of the developing networks around the country. It is proposed that there be time during the annual meetings for such discussions.

Previously there has been much debate about whether BAPM is a perinatal or a neonatal organisation. There was agreement that we should remain very much perinatal, although our agenda would reflect the important issues of the moment. As well as continuing to attract more obstetric membership it is important that we liase closely with obstetric, maternity and fetal medicine groups whenever perinatal issues are raised.

The issue about who we represent has become wider than just the perinatal/neonatal debate. There is an increasing membership of professionals other than doctors, including nurses, allied professionals and managers. These groups are now represented on the Executive Committee, as is BLISS who can give us the parental perspective. It is vital that we recognise and represent the needs of all our members.

It is not just the membership that is widening. The role of the Association is also expanding. Like all organisations, there is a need for regular reviews of our aims and priorities and this will be an important part of the annual meeting this year. The National Service Framework for Children, Young People and Maternity Services was published this year and it is important that we consider what opportunities this brings for development of perinatal services.

I will summarise some of the areas in which BAPM has been active over the past year. The challenge now is to decide if any change in our priorities is needed.

Consultation

BAPM receives a large number of papers for consultation. In many cases RCPCH looks to us for their formal response on behalf of the College. Where there is time I believe it important to circulate these papers, usually by e-mail, to members for comment, before putting together a response from

the Association. Unfortunately, the timescale is often short and this means that a prompt response from members is needed, if they wish to comment.

Nurse prescribing has been one of the issues in which BAPM has been closely involved. This is of vital importance to the long term functioning of many units. One of the major problems has been the definition of an independent prescriber in the relevant Medicines Act. The Medicines and Healthcare products Regulatory Agency (MHRA) circulated a consultation document on options for the future of independent prescribing by extended formulary nurse prescribers. The options offered implied that there was a willingness to review and change the law to allow independent prescribing by nurses. The response from BAPM to this consultation document is on the website. We supported strongly the option that advanced practice nurses could prescribe for any condition within their competence. We are waiting further feedback from this process.

Over the past year a number of members have raised anxieties about the reporting of neonatal deaths to Coroners. Across the country there is variation in which babies are reported and inconsistencies in the way these deaths are being dealt with by Coroners. The problem is mainly related to deaths following perinatal asphyxia, but there is also confusion around registration of babies born at the limits of viability. There are examples of units where there have been major disagreements between obstetricians and neonatologists. Coroners are autonomous and at present it is difficult to see how practice can be standardised. It is vital that neonatal and obstetric staff talk with each other and with the Coroner to determine local practice, preferably before a neonatal death occurs. There has been some discussion with the Coroners Society but this organisation does not have any power to alter practice. One way forward may be to organise a national meeting to discuss openly these concerns.

While on the subject of the limit of viability, members have previously requested some guidance on the management of such babies. The Nuffield Council on Bioethics is considering the issues around prolonging life in fetuses and the newborn. A consultation paper has been circulated and BAPM has responded. It is hoped that this process will lead to some useful guidelines in this difficult area.

The website contains the BAPM responses to all consultation documents.

Committees

The need to involve members more in the workings of BAPM was highlighted in the annual report two years ago. Since then, a number of sub-committees have been established and have reported on a range of issues. My thanks to all those involved in this work. The outputs from these committees are available on the website.

Consent

Increasing anxieties around the issues relating to consent for treatment were highlighted at a previous AGM. Professor Kate Costeloe has chaired a group that have produced a good practice framework for consent in neonatal clinical care. This is available on the website. A leaflet for parents will accompany these guidelines.

Neonatal Unit design

Dr Ian Laing, with others, has produced a report on designing a neonatal unit. This will be very useful for those involved in the planning of a new unit, particularly in these days of Private Finance Initiative.

Clinical excellence

A clinical excellence group, chaired by Professor Phil Steer, has been developing a web based system to collect and report perinatal critical incidents. Sharing important risk management messages from across the whole country is seen as an important development in clinical governance. The system is close to completion and I hope that members will support the implementation of this important tool.

Neonatal dataset

The work of the dataset group has been reported previously. Their review of the BAPM neonatal dataset is available on the website. Since the group's deliberations there have been a number of developments relating to neonatal data collection.

- Networks need good data collection for clinical care, audit and administration. Some networks are now quite advanced in their data collection systems and have developed their datasets.
- Health Resources Groups (HRG) are being developed in neonatal critical care, by a group chaired by Gary Hartnoll. These are to support the introduction of 'payment by results' and will require a neonatal dataset which will become mandatory.
- The Department of Health has given funding to the Healthcare Commission for the development of a system for National Neonatal Audit in England. RCPCH has put together the specification for this audit and at present are waiting to hear if they have been successful in their tender to implement the audit nationally. An initial dataset has been agreed as part of the project specification.

It is important that we prevent the development of a number of different datasets which do not relate to each other. Data should be collected once only and there should be agreed definitions across all units. The dataset group is

reconvening to consider how the BAPM dataset can be extended to include the needs of these other projects. It is hoped that this group will have a permanent role in the development of neonatal datasets, and in recommendations about how such data should be analysed and reported.

Guidelines

There is always some difference of opinion when the subject of guidelines is raised. Many members feel that BAPM should take a lead in development of clinical guidelines, while others are concerned about the way in which these may be used, particularly where good evidence is lacking. The RDS guideline has been reviewed by a number of groups and their recommendations coordinated, and summarised, by Professor David Field. The summary has been published on the website as a position, or best practice, statement on early management of the preterm baby. Where there is good evidence then it is expected that this will influence practice. If the evidence is weak the opinion of the group has been published to help and encourage units to develop their own local protocols and guidelines.

Research

For some years BAPM has had a standing committee focused on the issue of perinatal trials - the Clinical Trials Group, chaired by Peter Brocklehurst. The annual meeting organised by this group highlights the strong history of trials in neonatal and perinatal medicine.

You are probably aware that the Department of Health has set up a Medicines for Children Network, based in Liverpool, which will be part of the UK Clinical Research Network. This will allow the development of a more formal network through which clinical trials can be conducted, something BAPM and the Clinical Trials Group have been trying to achieve. An important aspect will be the involvement of the National Perinatal Epidemiology Unit and close liason with BAPM for trials involving the newborn. The Association has been asked to nominate a Chair for a Neonatal Studies Research Group (SRG) and I am delighted that Professor David Field has agreed to take on this task. The exact remit of this group is uncertain at this time, but I am sure David will help shape this in the right direction. What is certain is that trials prioritised through the SRG will have preferential consideration by the major funding bodies. This is an important opportunity to ensure that neonatal trials remain a high priority in the new research environment.

Training

BAPM has been closely involved with neonatal CSAC in setting standards and competencies, visiting units to assess neonatal training programmes and in the national grid selection process.

The trainees meeting last November was a success with some very useful feedback. The audience was mainly neonatal trainees but some obstetricians attended. A similar meeting will be held this year. The programme will concentrate on non clinical problems that trainees will face as consultants, e.g. management issues and difficult ethical decisions. The subjects will be aimed at both neonatologists and obstetricians. A useful part of the day is the 'surgeries' where trainees can get one-to-one advice on their career. It is hoped that all trainees will be encouraged to attend

Executive Committee

I have already mentioned the wider representation on the EC. It is important that regional representatives bring to the EC the concerns and ideas of their 'constituents'. There have now been very successful regional meetings and it is hoped that this model will be repeated across the country, with feedback to the EC.

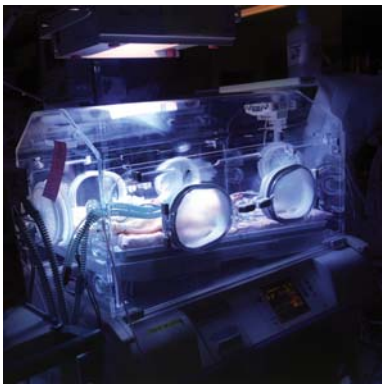
And finally

At this AGM, Professor Malcolm Chiswick hands over the presidency to Professor Neil Marlow.

Malcolm has been a great influence during his time as President. His experience and sensible, pragmatic approach have helped guide the Association. I hope he will continue to contribute to BAPM in the years to come.

I look forward to working with Neil and to watching how BAPM takes shape in the future.

A National Neonatal Audit



Neonatologists, neonatal nurses and parents all want to provide the best care with the best possible results. The DH through the Healthcare Commission is commissioning for an organisation to run this audit and the RCPCH with BAPM and other interested parties have put in a bid to do this. (will we be successful?). During the scoping process, wide consultation determined that what we, as professionals, want is the uniform collection of the BAPM dataset, with a few additional items based on the parental perception of quality of care. As the original BAPM dataset was about benchmarking medical issues, this is not inappropriate. However to be successful, a national audit needs to start small which is why the agreed audit data set consists of 22 data items addressing 9 clinical questions. We hope the number of items collected will expand in line with the BAPM dataset as units recognise the value of comparable data.

The audit will cover all babies admitted to a neonatal unit. In addition to the infant related data, there will be an annual survey of individual unit facilities and open cots. There will also be a separate 2-year follow up questionnaire on all babies who have received intensive care. This will allow benchmarking to type of unit, network and region combined with reasonable long term outcome information.

Wheels turn officiously slowly, but they do move and if we get the tender, hopefully we will escape enough of the officialdom to speed things up considerably.

There will be 2 methods of data collection, depending on whether a system exists at the moment at your unit. If it does, then the audit will “upload” the data from your existing system! If you don’t have a good existing system, your unit will be able to enter data directly on a web page.

The data collection from each unit will require time – allocated by each unit – the DH money doesn’t cover this aspect, but governance requires national audit to be done and the Healthcare Commission will eventually have to decide what sanctions it will make if Trusts do not contribute to national audits. Locally we all want this to happen, so it is really up to us make it work.

The BAPM is integrally involved in this process. We hope that after 6 months of data collection, comparative results will begin to become available.

Prof Neil McIntosh
Vice President, Research
Royal College of Paediatrics
and Child Health

Guidelines

As mentioned in the Secretary's report, there is always much debate, sometimes heated, about the whether BAPM should get involved in the development of clinical guidelines. Concerns have been expressed about the publication of any clinical guideline which is not strongly evidence based. Some feel that BAPM should be more concerned with setting standards for service configuration, organisation and delivery.

There is some confusion around the use of the word 'guideline', with several different interpretations being applied. I would agree with the Quality of Practice Committee (QPC) of RCPCH who state that the College will only consider backing a guideline where an evidence base has been properly sought. We should reserve the word 'guideline' for recommendations that have a strong evidence base (grade A, or possibly grade B, evidence).

The QPC emphasise that a properly produced evidence-based guideline is a major undertaking, and typically takes a motivated group two years to complete. However, they go on to say that, if evidence is lacking, there needs to be a degree of pragmatism in this approach. In such cases the opinion of a group of experts can form a useful 'Practice Statement'. Such statements will be noted by the College but with an attached disclaimer. However, units may find these very helpful when formulating their own local practice recommendations. There is a formal mechanism for turning these 'Practice Statements' into 'Consensus Statements' which, like evidence based guidelines, can be endorsed by the College.

There have been many requests asking that BAPM develop clinical guidelines. The Association has a wide membership with extensive experience and, if the members feel that guidelines are an important part of our work, it makes sense to tap into this expertise. This will require a great deal of work from members and there is little in the way of resources to help the process. I believe that we should use the model developed by QPC, and the College will be able to offer advice and guidance. It is hoped that groups can do much of this work electronically although there may be some limited funds from BAPM to support 'face to face' meetings if these were essential.

RDS guideline

The guideline for the Management of Neonatal Respiratory Distress Syndrome was written in 1998. This has been reviewed by the Quality of Practice Committee and some of the recommendations have been endorsed by the College. However, there have been further important publications since the original guideline was produced and this has therefore been reviewed.

The process of this review was coordinated by Professor David Field and involved setting up a number of groups to consider each section of the guideline. Most of the groups have now completed their work. The

recommendations are a combination of Evidence-Based Guidelines and Practice Statements. We have changed the title, from RDS Guideline, as it is clear that many of the recommendations are applicable to the early care of the preterm baby, whether or not they have RDS. At this stage they are available on the website as a 'Position Statement'. It is hoped that where there is good evidence the recommendations will affect practice. Where there is no evidence-base units must develop their own local practice recommendations. Practice Statements have been included to help with this process.

Once all the groups have reported, and the membership have had a chance to give feedback, the next stage will be to seek endorsement from the College for the Evidence-Based Guidelines and to consider if any of the Practice Statements can be turned into Consensus Statements.

My thanks to all those members who have contributed to this work, and in particular to David Field who pulled things together. The future priorities of BAPM are under discussion at this year's annual meeting. If guidelines are felt to be important, then let me know what areas you think need development. This work will be something that needs the willing involvement of members with the relevant expertise.

Alerts

With increasing centralised reporting of adverse events another mechanism for 'protocol' development is emerging. As a response to alerts, e.g. from Department of Health or Medicines and Healthcare products Regulatory Agency (MHRA), Trusts are being 'forced' to make alterations in clinical practice.

The concern is that these are often a 'knee-jerk' response and not necessarily based on any good evidence-base. A recent example in neonatal care has been an alert from MHRA about the use of litmus paper to check the position of nasogastric tubes. There have been serious adverse reports in children and adults about misplaced tubes causing harm, or even death. The response was to recommend a change to pH paper without any evidence that the underlying cause was entirely due to the use of litmus. The initial guidelines circulated by the National Patient Safety Agency (NPSA) did not address the specific problems of the newborn baby and BAPM was quick to inform MHRA that they had not given any thought to how this would impact on neonatal care.

BAPM has subsequently been working with NPSA to produce a practical and safe protocol for neonatal units. Although there is little evidence-base to support change to what has been long standing practice within neonatal units, the move from litmus to pH paper will become mandatory. More work is needed in this field but I hope at this stage that we have been able to produce a safe, yet practically simple, protocol for neonatal units to adopt.

I have concerns about this way of developing 'guidelines' but it is likely to become more common. It is important that BAPM is involved and can influence any centrally developed protocol that impacts on the clinical care of the newborn baby.

Dr Andrew Lyon
Honorary Secretary

Transport – Minimum Dataset

Over the last few years a substantial community of doctors, nurses and others with transport interests has emerged nationally and neonatal transport has attained a higher profile. The development of neonatal networks has focussed attention on the need for parallel development of transport services. Diverse models of transport provision operate in the UK, from ad hoc teams with little preparation assembled in response to need through to dedicated teams with substantial resources. With such diverse provision it is likely that there are wide variations in standards between services. Whilst many transport services collect activity and quality indicator data, there is no standardisation of data items or mechanism for cross-centre comparisons.

With this in mind BAPM have sponsored a working group to develop a common minimum dataset for neonatal transport. The main benefits of the project will be:

- Comparisons of clinical data that will allow for investigation of apparent differences between centres, which in turn may facilitate best-practice identification and dissemination.
- Local quality improvement programmes may follow from comparison with national averages.

The initial meeting in June of this year achieved consensus on data items to be collected on all transfers with regard to:

- Categories of care
- Timing and personnel involved
- Biophysical data.

In addition each transport service would complete an annual return regarding:

- Team composition and status
- Vehicle supplier
- Number of airborne transfers
- Number of deaths.

There was also consensus that:

- Individual patients should not be identifiable in reports
- Individual patients should not be named in data returns
- Transport teams should be able to identify their own data in comparative tables of dataset reporting.

Further work is required in the areas of reporting regarding whether this should be an on-going exercise nationally or whether periodic collation and reporting of data would be more appropriate. Data could also be used to produce national guidelines for a good practice framework. Clearly this project overlaps with other BAPM data projects and there may be scope for integrated implementation. Interested parties wishing to comment on or contribute to the project should send comments by the end of September 2005 to Andy Leslie or Alan Fenton.

Dr Andrew Leslie and
Dr Alan Fenton
Representatives on BAPM's
Executive Committee

South of England Regional Meeting

This year's South of England regional meeting was held on Wednesday, 20 July 2005 at the RCPCH, London, attended by representatives from 11 of the 14 Neonatal Networks in the South of England.

The agenda included a review and discussion relating to the Maternity Services NSF, an update concerning the SEND (data collection) project, and a presentation relating to "EPICURE 2". Reports were presented from each of the Networks relating to their stage of development, and current and future challenges. The main themes which emerged were as follows.

1. **Transport.**

   Most of the Networks reported good progress in the development of transport systems for sick neonates. However, most are provided only on a "part-time" basis and systems for in-utero transfers seem to be variable and, in some areas, in need of improvement.

2. **Data Collection**

   The SEND data collection system - an "online" system - is being used by a number of Networks in the South and has the potential to fulfil the requirements for BAPM dataset collection and for providing a unified clinical record for babies, including those who are cared for in more than one unit.

3. **Collaboration Between Units**

   There is increasing collaboration between units within the Networks and most have formed groups which are developing common Network guidelines/protocols.

4. **Obstetrics/Midwifery Services**

   Involvement of Obstetrics and Midwifery services is variable. Many of the Networks have agreed guidelines for transfer of mothers with "at-risk" pregnancies.

5. **Future Models of Medical Staffing**

   A number of representatives raised concerns about the workload for medical staff, particularly for tertiary-level units. There was a view that, in the future, there may be a need for enhanced round-the clock structures to provide comprehensive neonatal medical cover for neonatal and maternity services in which, for example, more than one consultant neonatologist may be available.

Michael Hall
South of England
Representative on BAPM's
Executive Committee

Newborn Networks

Newborn networks present an enormous opportunity to improve patient care, in moving away from the traditional hierarchies of centres and peripheries, and moving towards seamless care for a given population, ensuring that mothers, babies and their families get the best care as close to home as possible. Doesn't that sound great? It is – but it requires a leviathan effort from all those involved, putting aside historical differences, resolving organisational and personal ambitions, placing patients before existing administrative and management imperatives. Managers and clinicians alike have their role to play in making this happen, and delivering improved patient care.

The starting move for newborn networks is to define their membership and scope – are they just responsible for NIC, or the whole of neonatal services, or do they include perinatal, maternity and obstetric services. It will come as no surprise that there is not universal agreement on this. The prevailing view, and probably the correct one, is that they must cover all of these services – the difficulty with that is that it makes for an even more complex series of issues.

Having agreed the scope of the service (probably including neonatal surgery, cardiology, transport and retrieval etc), there is then a need to agree membership and representation without making the network board dysfunctional in terms of size and nature, and the question of who's in and who's out consumes vast amounts of energy. Designation and decision making come next on the list, effectively agreeing changes to service configuration in line with recommendations of the 2003 Department of Health Review of neonatal services. This is the most contentious of all of the network's tasks, and demands significant effort from all those involved, as well as an ability by all to regard the wider picture, not just local issues. Often these processes may be seen as a judgement on the quality of services provided, when in fact they are an effort to support all services in their delivery of patient care – a fact often missed. Ensuring parent and carer involvement and representation is complex and demanding but in the West Midlands we have the good fortune of BLISS supporting the recruitment, training and ongoing support of user representatives to network boards.

Newborn networks seem to be progressing, undertaking work and moving towards reconfigured and improved services – time will tell in terms of the real test of such changes – improved outcomes. Newborn networks will only work and improve care for mothers and babies if there is a collective will for their success – a good and strong chair, as well as lead clinician and network manager are essential in the smooth working of a network – to lead the collective, and arbitrate where necessary. The jury is still out on networks' ability to deliver improved health services per se, and part of that ongoing evaluation will depend on the success of newborn networks in improving care.

Simon Brake, Specialist Commissioner and Deputy Representative for Allied Professionals on BAPM's Executive

Financial Statements for the year ended 31 March 2005

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 (to Sept 2004)
Dr Andrew Lyon (from Sept 2004)
Dr J Ahluwalia, 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 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 2005.

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 and a professional society of the Royal College of Obstetricians and Gynaecologists.

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 2005, which are set out on the following pages.

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 G McDonald FCCA
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 2005

	Note	Unrestricted Funds	Restricted Funds	Total Funds 31/03/05	Total Funds 31/03/04
Incoming Resources		£	£	£	£
Subscriptions and donations		59,093	-	59,093	58,996
Dunn donations		-	-	-	10,000
Annual General Meeting surplus		13,808	-	13,808	2,264
Course/membership list income		1,077	-	1,077	923
CTG meeting income		3,290	-	3,290	1,550
Trainees meeting income		4,020	-	4,020	5,490
Bank interest receivable		4,577	4,921	9,498	5,162
Total Incoming Resources		85,865	4,921	90,786	84,385
Resources Expended					
Management and administration costs	4	83,026	-	83,026	75,738
CTG meeting costs		3,213	-	3,213	2,266
Trainees meeting costs		5,816	-	5,816	4,582
Founders lecture fee		-	275	275	320
		(92,055)	(275)	(92,330)	(82,906)
Net (Outgoing) / Incoming Resources for Year		(6,190)	4,646	(1,544)	1,479
Funds brought forward at 1 April 2004		127,646	107,687	235,333	233,854
Funds carried forward at 31 March 2005		121,456	112,333	233,789	235,333

Balance as at 31 March 2005

	Note	31/03/05 £	31/03/04 £
Fixed Assets:			
Presidential badge (at cost)	6	1,000	1,000
Current Assets:			
Debtors	7	15,948	21,495
Standard Life Bank - Savings		30,000	-
Standard Life Bank - Dunn library fund		95,500	90,000
Standard Life Bank - Dunn library fund		262	724
Standard Life Bank - Founders lecture fund		15,000	15,000
Standard Life Bank - Founders lecture fund		946	224
Standard Life Bank - Premium notice		94,063	85,711
Bank of Scotland - Premier bonus		1,504	48,743
Bank of Scotland - Treasurer		-	2,522
HSBC - Business money manager		-	3,950
HSBC - Treasurer		4,869	3,364
		258,092	271,733
Current Liabilities:			
Creditors: Amounts falling due within one year	8	(25,303)	(37,400)
Net Assets		**£233,789**	**£235,333**
Unrestricted Funds		121,456	127,646
Restricted Funds		112,333	107,687
Total Funds	9 & 10	**£233,789**	**£235,333**

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 £309 (2004: £190) to Dr Ahluwalia, £161 (2004: £496) to Prof Field, and £258 (2004: £386) to Prof Chiswick and £798 to Dr Lyon 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

	31/03/05	31/03/04
	£	£
Office administration and accommodation costs	64,206	50,231
Meeting costs	7,420	5,955
Newsletter costs	1,667	2,207
Independent examiner's remuneration (see note 5)	2,673	2,644
Other	7,060	14,701
	83,026	75,738

5. Independent Examiner's Remuneration

	31/03/05	31/03/04
Independent examiner's remuneration is as follows:	£	£
Independent examination	705	705
Other financial services -		
- year ended 31/3/04	-	1,939
- year ended 31/3/05	1,968	-
	2,673	2,644

6. Tangible Fixed Assets

Presidential Badge	£
Cost:	
At 1 April 2004 and 31 March 2005	1,000
Net Book Value:	
At 31 March 2005	1,000
At 1 April 2004	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

	31/03/05	31/03/04
	£	£
Subscriptions, etc.	980	3,205
Income tax recoverable	9,267	9,449
Prepayments and accrued income	5,701	8,841
	15,948	21,495

8. Creditors: Amounts falling due within one year

	31/03/05	31/03/04
	£	£
Accruals	25,303	37,400

9. Analysis of net assets between funds

	Unrestricted funds	Restricted funds	Total funds
	£	£	£
Fixed assets	1,000	-	1,000
Current assets	145,759	112,333	258,092
Current liabilities	(25,303)	-	(25,303)
Net assets at 31 March 2004	121,456	112,333	233,789

10. Movements in funds

	At 1/4/04	Incoming resources	Outgoing resources	At 31/3/05
	£	£	£	£
Restricted funds:				
Dunn - Library fund	92,603	4,203	(-)	96,806
Dunn - Founders lecture fund	15,084	718	(275)	15,527
Total restricted funds	107,687	4,921	(275)	112,333
Unrestricted funds:				
General funds	127,646	85,865	(92,055)	121,456
Total funds	235,333	90,786	(92,330)	233,789

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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