Annual Report 2008

BRITISH ASSOCIATION OF PERINATAL MEDICINE

Founded 1976

From the President

As my final year as your President draws to a close, it is good to look back on a year that has been particularly full of achievements. We have seen several important changes not the least being the move with the RCPCH to 5-11 Theobalds Road and the improved estate we have there. We were sad to lose Julia Wheal who worked with us for five years and who was a real asset to the office and Association. We have recently been joined in the office by Lizzy Noble whom we welcome and look forward to working with her over the coming years.

This year has been a busy one for the Officers and Executive Committee in terms of productivity and of interaction with other organisations. I am grateful to those EC members who have taken on roles on behalf of BAPM and contributed to a range of national initiatives and documents. BAPM has been in great demand this year in a range of forums from the Science and Technology Committee of the Houses of Parliament, through the launching of major initiatives by BLISS and Action Medical Research to representation on a range of RCPCH, RCOG and other committees.

We have two new publications this year – reports from Working Groups on Health Status at 2 years and the Framework for Management of Babies Born Extremely Preterm – and the Perinatal Palliative Care Working Group has a draft report. A statement on enrolment in multiple research studies has recently been published in the Lancet following discussions within the Perinatal Trials Group. The trials group has not had a formal scientific meeting this year and a decision as to how we progress this will need to be made at the forthcoming AGM.
One area that is evolving is that of how we interact with initiatives around perinatal data collection. The EC took a unanimous view that it needed to review data issues on a regular basis rather than use a standing group. This then allows us to undertake specific pieces of work as required. At present this is important as the National Neonatal Audit project is beginning to collate data and data issues for the commissioning of neonatal services are central to the national Taskforce considerations, of which more later. It is important that decisions of how we move these initiatives forward come centrally within BAPM business.

Much has been discussed around a revision of the BAPM Standards document published in 2001. We have looked at it again and in fact there is little that really requires change; to embark on this just as new commissioning contractual arrangements are evolving, which will be based on these, may be unhelpful. It may be necessary to formally review them in the future but at present they provide a substantial basis for contracting. Clearly there are newer areas of recommendations such as Safer Childbirth (October 2007), but these simply refine in more detail the principles in the Standards document and can easily and should be combined. The RCN hosted a neonatal nursing summit and it is highly likely that the statement from this group will absolutely confirm the need for nursing establishments as detailed in the Standards as minimum requirements, as we approach the original target for implementation of 2010. This too is important as little work has been done to determine the true cost of moving to these Standards, which should be based on activity rather than notional cot numbers. We fully support the new BLISS 1-2-1 campaign that is being launched this autumn. Confirming these important principles will underpin network activity and re-designation processes that are ongoing, as the new Specialist Commissioning Groups start their work in many areas of England.

The most significant event of the year for Neonatal Medicine has been the commissioning of the national Neonatal Taskforce under the chairmanship of the NHS Medical Director Professor Sir Bruce Keogh. This NHSE-led group has established 4 working groups to look at data and commissioning, transport, surgery and workforce. These are now in full swing and will report in the Spring to provide a framework to support commissioning of neonatal services based on agreed datasets, quality standards and structures. There is goodwill centrally to sort this out and we look forward to the output of this group in 2009. Many network managers, nurses and clinicians are involved in these working groups and I am grateful to all of them for giving their time to make sure this is a rigorous and effective process. There will be communication events to seek opinion from staff at all levels so please engage with these when they are announced. I think this is our best chance to attract a structured approach to resourcing newborn care for many years.

Back to more traditional areas and we have had three very successful educational meetings over the past 12 months – a well attended Trainees Meeting, a high quality Perinatal Session at York where the keynote speakers were excellent and proved very popular on feedback and finally, we were delighted with the response of the membership to Perinatal Medicine 2008 in Harrogate. This meeting was the first between four UK perinatal societies and attracted in excess of 800 delegates. The feedback from all of the sessions was very positive and the quality of the scientific presentations really high. We were a little unprepared for the numbers of people wanting to attend the BAPM/Neonatal Society sessions which meant that the speakers were playing to a packed house, but overall the general feedback about the venue, entertainment and programme was very positive. I do hope this is something we can repeat in the future. For the immediate future we have the clinical governance forum following the AGM and this dovetails nicely in with the NPSA Safer Neonatal Care initiative, led by Neena Modi, where care bundles for prescribing, infection prevention and transport are being developed. I am sure these areas will continue to challenge us in the coming years and I look forward to the new tools we will have to help us address such critical issues.

So it is with some regret that I come to the end of my last report to you. I believe BAPM has a bright future and is well established as an important professional group. I offer David Field all my best wishes as he takes over from me and it is reassuring that the Association will be in such competent hands. Of course, in my role I am only as good as the team that I have been working with. Initially Andy Lyon, and more recently Bryan Gill have proven themselves highly effective Honorary Secretaries and I thank them both for their help and support. Lisa Nandi has now completed her first full year with us and really has excelled as the keystone of the Association; without her the show would certainly not go on. I must also thank Jag Ahluwalia who has now almost completed his extended term as Treasurer – Jag has been an incredibly good pair of financial hands and has taken a full and important role in the running of BAPM during his tenure. I am really grateful for his counsel and support and, believe me, I am heartily relieved we managed to turn in a profit following our meeting in Harrogate as I suspect he would have held me to account if we had not!

Finally can I thank all of the membership for their support over the past three years. It has been my privilege to be your President and I wish the Association well for the future.

Neil Marlow

Objectives	Activities during 2007-2008
Providing postgraduate education meetings throughout the year	• BAPM's Annual General & Scientific Meeting held in September • The Perinatal Session of the annual Spring Meeting of the Royal College of Paediatrics and Child Health (RCPCH) • Perinatal Medicine 2008 - joint meeting with BMFMS, Neonatal Society and Neonatal Nurses' Association
Facilitating clinical trials and other research	• Ongoing support and advice for those setting up and/or running perinatal clinical trials in the UK • Providing information for members on the progress of current perinatal clinical trials • Representation on Neonatal Studies Research Group (part of Medicines for Children Network)
Advising on training and education in perinatal practice	• BAPM's Annual Perinatal Trainees Meeting held in October/November • RCPCH Specialist Advisory Committee (Neonatal Medicine) – setting competencies for higher specialist training and appointing to National Grid posts for Neonatal sub-specialty training • RCPCH Specialty Board
Providing advice to Government and other professional bodies on developing and improving perinatal care **and** **Raising awareness of and proactively influencing the policy environment in which perinatal care is delivered**	NHSE Neonatal Taskforce Houses of Parliament Science & Technology Committee (on lowering limit for abortion) NHS Next Stage - response to review by Lord Darzi RCN - Neonatal Nursing Summit Department of Health Midwifery Steering Committee 2020 RCOG, RCM, RCA and RCPCH Report on Safer Childbirth: Minimum Standards for Organisation and Delivery of Care in Labour King's Fund - "Safe Births:Everybody's Business" - Inquiry into the Safety of Maternity Services in England NHSLA - Maternity Risk Management Standards BLISS - 1-2-1 campaign and Baby Charter
Auditing and monitoring the outcome, structure and function of perinatal care for babies and their families	• Data Working Group • Neonatal Data Analysis Unit • National Neonatal Audit Project • National Patient Safety Agency • Neonatal Network Managers Group • Working group on management of babies born extremely preterm • Working group on health status at two years as a perinatal outcome • Working group on perinatal palliative care • In utero transfers : a framework for management
Fostering fellowship and collaboration among those involved in the care of the pregnant woman, mother and baby	• Email bulletins, Newsletters, Website, Networking opportunities during meetings • Links with other organisations involved in perinatal care eg professional associations and colleges, parent organisations etc.

Honorary Secretary's Report

At the time you read this, I will have reflected on the past 12 months as your Honorary Secretary. I must admit that I had not appreciated the amount of work, at times, that this has entailed. It is also possible that I have not communicated with the membership as some would have expected. I have therefore started my report by asking the membership to let me know how I can improve.

Our move to the new RCPCH building in Theobalds Road has been a success, despite the problems we had with sorting out the lease. We believe we will benefit from free access to the rooms for meetings and conferences and have made progress with regard to housing Peter Dunn's collection of books and pamphlets (his legacy to BAPM) in an appropriate facility in the College.

Our President has outlined many of the areas we have been working on and I would like to focus on the representative work and neonatal outcome data.

The formal submission and oral presentation we gave to the Science and Technology Committee on the issue of lowering the limit for abortion did cause the Officers some concern, as we had not formally consulted the membership on our stance. We aimed to be very careful that we focussed on the best evidence available when being asked the question of long term outcome. As with many of these political agendas, our involvement in the process was not likely to have a major impact on the subsequent voting of MPs. It did however highlight to me that we need to improve

our mechanisms for obtaining the views of our members. It is our size, diversity of backgrounds and likely differing views that is one of our major strengths. We do need your opinions on key national issues in perinatal care and I envisage this will become increasingly important as we engage further in the new taskforce work.

Bliss continues to lobby very hard to improve neonatal care. They have submitted an application for support from the Association for a specific lobbying campaign to meet the 1:1 nurse staffing standards in neonatal intensive care. The Officers have committed to the Association supporting our 1:1 staffing standard. However, the request from Bliss for financial assistance for this campaign took us a little by surprise and we concluded that firstly, we needed to establish if our constitution permits us to do this and secondly, whether the membership consider this to be the direction in which we should be going. This will be discussed for the first time at

Honorary Secretary's Report (cont)

the AGM. If you were unable to attend please send us your view on whether, in principle, BAPM should be using its resources to provide financial support to lobbying campaigns.

The issue of neonatal outcome data is probably the single largest issue that has been up for discussion amongst members. This will be discussed at the AGM and is at the heart of one of the four neonatal taskforce workstreams for the next 12 months.

Your input into what we should be reporting on as a reflection of neonatal care is extremely important, as we appear to have an opportunity to embed this into commissioning standards for neonatal care. In my role as Honorary Secretary, I have been involved with the NNAP project as a member of the steering group. It is worth noting that the Healthcare Commission and DH are impressed by the work achieved so far. Whilst we can argue endlessly about the level of detail and value of some of the questions, it is the only project across the UK that has the chance to provide the same data and allow benchmarking for our services, even if it is at a relatively high level. This has not been achievable before. If your neonatal service is not contributing then I would urge you to consider doing so.

Honorary Secretary's Report (cont)

Neonatal training and the role of the RCPCH SAC have become more integrated. Jane Hawdon has been acting as the BAPM representative on the Neonatal SAC until I complete my role as Chair (September 2008). It is hoped that BAPM will have a greater role in the future by increasing the number of neonatologists on the committee. Naturally this needs approval from the RCPCH. The Perinatal Trainees' day appears to be a well-established meeting for neonatal trainees as evidenced by the very positive feedback from the attendees. The next meeting will be held in November at the Royal Institute of British Architects in London. Please do encourage your trainees to attend (details are available on the BAPM website: www.bapm.org).

As Neil has said, we have had two successful meetings in York and Harrogate, (as I keep telling people, Yorkshire is a great place!). I hope that the Perinatal Medicine meeting can be repeated and I will encourage BAPM to lobby in the future to do so. The fact that we made a profit, (Jag would call it a surplus) adds greater support to its continuance.

The Officers remain concerned that we are struggling to reach out and meet the needs of the obstetricians within BAPM, and to attract new obstetric members. I believe that developments such as the BMFMS have diminished the perceived value of BAPM and I feel, as I suspect many do, that we can co-exist as we are focussing on different elements of perinatal care. We provide the link between antenatal/intrapartum and post-natal care. Our work on palliative care will be an example of the value of this linkage. However, we cannot ignore that we may need to think further about how we develop ties to other obstetric/midwifery groups to improve perinatal care. The RCPCH, BAPM and RCOG recently relaunched the biannual tripartite meeting to share common themes. I would like to take this opportunity to thank Bill Martin for his contribution on what is happening in obstetrics to be found later in this report.

I do hope you enjoy this year's AGM. I have deliberately focussed on the high level issues. Other areas of work including links with external bodies (RCOG, NPSA, HCC) have been undertaken, and I will continue to feedback on these through the newsletters and email bulletins. The next 12 months will be heavily focussed on the neonatal taskforce which we all hope will produce sustainable improvements to neonatal provision and care.

I look forward to working with David Field, our new President and new members of EC. I would like to extend my enormous thanks for all the guidance and support from the EC team, in particular Lisa Nandi (and Julia Wheal) for keeping me on track, Neil for his leadership (and for improving my grammar!) and Jag, our esteemed Treasurer for his contributions to developing consensus decisions. He is just as amusing at EC meetings when presenting financial information as he is at the AGM!

A Bryan Gill

Nursing and Midwifery update

Since last year, a number of key documents have been released that have the potential to act as drivers for change within Neonatal Nursing and Midwifery.

Most significant for us appears to be the recognition of the deficit in staffing numbers in both Nursing and Midwifery following the NAO report and the HCC review of Maternity Services. There is now a greater emphasis in trying to achieve the standards of BAPM 2001 and Birthrate Plus. BAPM has been invited to join the Neonatal Workforce Stream of the Neonatal Task Force where nursing issues can be debated and suggestions for improvement made.

This gives us an excellent opportunity to emphasise the standards that are required to deliver safe and effective care. I have heard in this last year from a number of different sources that the BAPM 2001 standards are outdated and were an idealistic gold standard, with no evidence base. The recent nursing activity studies from Newcastle remind us that a baby in intensive care does need one to one nursing and that this should not be seen as the gold standard, but is in fact the level of nursing care that babies actually need. Consequently the message will need to be that the BAPM 2001 standards are as relevant today as they were in 2001.

Another key matter that has arisen during the course of this year is the DH work around Modernising Nursing Careers. Consultations have been released for proposals to change both pre and post registration structures. It now looks certain that the DH will forge ahead with its plans to redefine career pathways into the proposed 5 domains. Midwifery and Neonatal Nursing appears to sit within the children, family and public health pathway; however, what the consequences will be for our specialities is unclear currently.

The pre registration consultation asks the question whether nursing should become an all-graduate profession and remove the branch training. Wales has held degree only education since 2004 and Neonatology does not appear to have suffered from this change. Nevertheless, the proposals in England also suggest moving away from the current branch training. This could have significant consequences for us although we do draw nurses from all the branches, and then give post registration training following recruitment. Again, the consequences of this change are unclear. Time wise, these are more likely to be matters that Sue Turrill will consider when she takes the mantle from me.

I am delighted that Sue Turrill is now the Nursing and Midwifery Deputy; some of you may know her in her University Lecturer role. The Nursing and Midwifery numbers in BAPM are small but not insignificant and I feel our contributions to the Executive of BAPM are worthwhile and valued. Sadly, I was not able to get to this years conference “Perinatal Medicine 2008” but I have heard from a number of people that it was excellent and I am pleased so many people benefited from it. I hope to see you at the AGM as we move into a year that may hold many challenges for Neonatal Nurses and for Midwifery.

Alison Gibbs

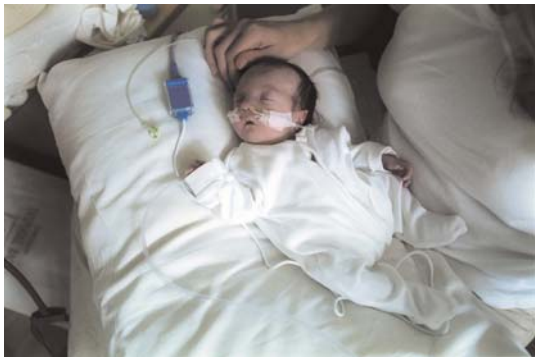
Professions allied to medicine

This year there is to be a taskforce jointly established by The Department of Health and the NHS to look at neonatal services; it has been prompted by the National Audit Office report “Caring for vulnerable babies; the reorganisation of neonatal services in England” published in December 2007. The purpose is “to support the NHS to identify and deliver real improvements to neonatal services”. In taking forward its work, the taskforce will consider recommendations in the NAO report. It will very much be a ‘doing’ group, driving and supporting SHAs to deliver the improvements needed in their areas.

Part of this review involves an appraisal of workforce issues and AHPs have been approached to represent their colleagues. This is a welcome move as there was no mention of AHP involvement in neonatal care in the NAO report; the growing use of therapists specialised in neonatal care needs to be acknowledged and benchmarked.

The taskforce is not due to report until late in 2009, by that time there should be a good assessment of the role of AHPs in neonatology with some bench marks in place. A welcome outcome would be an increased interest from members of the allied health professions in joining BAPM.

Having said that, there was representation at the inaugural conference “Perinatal Medicine” held in Harrogate at the beginning of June with approximately 20 AHPs attending. In the grand scheme this was still only around 2% of the total delegate list, so there is a challenge to increase this at the next conference.



In the meantime, I would encourage BAPM members and their colleagues to go to the BAPM website and look at the dietitians web page for updated information. There are links to other useful websites, information on joining our listserve to exchange nutritional information, a bibliography and relevant guidelines and position statements. In addition, there are plans for a monthly review of the paediatric and neonatal literature to highlight any topical papers on neonatal nutrition.

Finally we are still hoping for comments on our web based nutrition tool NATIV (nutrition assessment tool for iron and vitamins). Anyone interested please contact Chris Jarvis Chris.Jarvis@nottingham.ac.uk.

Caroline King

Report from Obstetric Representative

The British Association of Perinatal Medicine was conceived as a society to bring together all those involved in the care of pregnant women and their babies; to identify common themes and represent common views.

The main interface between the neonatal and obstetric teams is on the delivery suite. When the team works together as it should (and usually does), with communication and cooperation at its best, outcomes are good and are ever improving in the face of increasing challenges. There can though, be more than a physical distance between the Labour Ward and the Neonatal Unit. This is usually because of a lack of appreciation of the pressures that the other is under. Often these are staffing pressures that sap resolve more than anything. It is this team working and the results that it produces that needs to be fostered to continue to improve the care received by the women and their babies delivered in the UK.

Are the aims of the society being achieved? In the past there has been an Obstetric President (Professor Steer). Obstetricians serve on the Executive Committee and have attained offices in the Society, and they are represented in the membership. This is mainly at consultant level and there are few trainees that are members, in contrast to the neonatal/paediatric membership where trainees are well represented. We have to consider why this is and to engage with that section of the profession. There are a number of representatives from the allied professions, however no midwives are involved in the society to my knowledge. We need to be relevant to our current and future membership. For example, amongst obstetricians who are we trying to attract - the Fetal Medicine subspecialist or the more general Obstetrician?

BAPM is perceived as a Neonatal/Fetal Medicine society when in reality the issues we address are problems faced by all obstetricians managing a delivery suite and anyone managing a neonatal unit. Thus to remain relevant we need to engage all concerned. The recent joint Perinatal Medicine 2008 meeting in Harrogate of the British Maternal and Fetal Medicine Society, BAPM, the Neonatal Nurses Association and Neonatal Society went a long way to addressing this and it proved to be very successful. It was gratifying to see submissions from trainees of a high standard. A mixture of

clinical research and scientific papers were submitted. Presentations were of corresponding quality. Combined plenary sessions were truly perinatal and the presentations were excellent. The attendance was gratifying in the context of a plethora of specialist and scientific meetings that are available to the medical profession, and the obvious popularity of the event will surely lead to further similar ventures in the future.

As this is an Obstetric report and it has been some time since such a report was included in the annual report, it is (hopefully) interesting and relevant to consider what has influenced Obstetrics and what direction it is going in. In recent years there have been a number of publications that have and are influencing maternity care in the UK. Many of these have been jointly written by the RCOG and RCPCH. There are many aspects of Obstetrics and Neonatology that are similar, not least the acute and unpredictable nature of the work. The challenges are growing. With improvements in neonatal care the limits of viability are ever decreasing. These babies require more intensive care for longer. These issues create dilemmas for the obstetrician - for example, deciding when and how to deliver a baby of extremely short gestation. Advances in fetal medicine have allowed intervention and survival of babies that would previously have died *in utero* creating problems for the neonatologist. It is certain that care will continue to evolve and that these challenges will only continue and create more pressure on the services we provide.

Report from Obstetric Representative (cont)

In 2004, the Department of Health published the *National Service Framework for Children, Young People and Maternity Services* which has a ten-year timeframe for implementation. This introduced the concept of newborn networks to ensure that there is equality of access to appropriate care. This has been implemented at differing rates across the country and any benefits are only just beginning to be realised. The initial goal was to realise the improvements within 10 years (by 2014), the Government subsequently indicated an intention to introduce many of the provisions by 2009.

More recently *The Safer Childbirth: Minimum Standards for Service Provision and Care in Labour* report was produced in collaboration with the Royal College of Midwives, the Royal College of Anaesthetists and the RCPCH. The Healthcare Commission, the National Patient Safety Agency and the Clinical Negligence Scheme for Trusts were also represented. This report lays out how intrapartum care should be organised in maternity units. It highlighted a number of factors, which included evidence from the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) and the Confidential Enquiry into Maternal Deaths in the United Kingdom (CEMACH), both national audits with valuable lessons for all involved in the care of women and their babies. The main issues were staff shortages, both midwives/nurses and doctors; changes in organisation of perinatal care/perinatal networks and their impact on development of care for women in labour; changing expectations and choice; patient safety; medical litigation; improving morale and teamwork.

A recurring theme in this and other publications was the importance of a consultant presence on the delivery suite. Changes in training have had an impact of the experience of junior staff. The CESDI reports have highlighted experience as a key factor in reducing risk, and thus increased involvement of consultants on the labour ward in the care of women with complicated pregnancies and in the supervision and education of medical staff is inevitable and invaluable. It is intrapartum care that remains the most significant source of litigation. Problems highlighted as causal may well be ameliorated by a consultant presence. However, to implement the target of consultant cover 168 hours a week will require a huge investment in manpower, offset it is hoped by the consequent reduction in the aforementioned litigation?. The implementation of this cover is due from 2010; whether this is achievable remains doubtful but there is no doubt that in busier units, 24 hour consultant cover will occur and in the very near future.

Potentially one of the most influential reports in recent times is the *NHS Next Stage* review by Lord Darzi. This sets out a grand vision of the future NHS but whilst laudable, the proposals need investment as they will not come cheap. Within the proposals come recommendations that patient choice of where and how to deliver should be available to all including the disadvantaged. Clearly choice is to be highly commended and within obstetrics there is a drive to de-medicalise the physiological process of child birth. It needs to be considered though that these processes can go wrong and if this happens in a home birth, then the neonatal outcome is likely to be compromised irrespective of how well the attendants are trained at resuscitation. There are also those that find it reassuring to deliver in hospital and they must be catered for. Midwifery-led units are a good compromise. These are run by midwives for low risk women and can provide a home birth environment with the built-in safety of knowing obstetric and neonatal services are a short distance away. In terms of patient satisfaction they score highly in surveys.

There are a number of changes on the way. Many of them will have profound effects on how we work now and how the current juniors work in the future. Overall, these changes are for the better. With the shortening hours of work and time to train, consultant presence on the delivery suite should improve the quality of the care the women receive, both now and in the future. The Newborn networks are aiming to ensure that care is received in the most appropriate environment. The number of initiatives seems to be ever increasing but it takes time to tell whether a change has succeeded or failed. It would be beneficial to allow the current systems to be tried and tested before deciding on further change.

Bill Martin

Clinical Trials Group

BAPM Clinical Trials Group

Although there has been no formal meeting of the BAPM Clinical Trials Group since the last Annual Report, there continues to be a lot of activity in the field of clinical trials within perinatal medicine. The Medicines for Children Research Network continues to develop its activity and become established as part of the new research infrastructure within the UK. Specifically for us in perinatology, the work of the Extended Neonatal Network has continued and is proving to be a valuable resource for the MCRN, as many neonatal trials and other studies are not limited to the geographical areas covered by the Local Research Networks of the MCRN. Sara Lewis, the Extended Neonatal Network Co-ordinator, based at the National Perinatal Epidemiology Unit, is still interested to hear from centres who are not currently part of the Extended Neonatal Network. She can provide support for developing permissions to participate in research and can be contacted at www.npeu.ox.ac.uk/neonatalnetwork.

The National Reproductive Health Research Network

Another interesting development over the past year is that the RCOG have recognised that the new research infrastructure in England, with the Comprehensive Local Research Networks (CLRNs), does not include any funding or support for portfolio development. Portfolio development is the strategic development of new research projects to reflect national priorities and needs. Within the topic-specific research networks, such as the Medicines for Children Research Network, this strategy of portfolio development was included in the original remit and was funded. As there are not going to be any further topic-specific networks, the role of portfolio development has been left to the academic community. The RCOG have recognised this as an issue in reproductive health research and had set up the National Reproductive Health Research Network (NRHRN). This network, run by a small executive including the President of the RCOG, is tasked to develop a number of Clinical Study Groups (CSGs) within reproductive health care which are analogous to those in the topic-specific research networks.

The first of these CSGs is the Preterm Birth CSG, chaired by Professor Steve Thornton from Warwick. The Reproductive Medicine CSG, under the chairmanship of Professor Bhattacharya has also been established. Other CSGs are in the process of being discussed and established with support from the relevant specialty groups within obstetrics and gynaecology. Information about the NRHRN can be found on the RCOG website, at this link: http://www.rcog.org.uk/index.asp?PageID=61

Recruitment of neonates to multiple trials

Other developments over the last year include an article published recently in The Lancet (Beardsall K, Brocklehurst P, Ahluwalia J. Should newborn infants be excluded from multiple research studies? Lancet 2008; 372: 503–05) which discussed the challenges of recruiting neonates to more than one study, including to more than one randomised controlled trial. Hopefully this article will stimulate discussion and can be used by ethics committees in the future to inform their decision making.

Funding for clinical trials

The other major development in clinical trials is the greatly increased funding opportunities for clinical research under the new NIHR funding structures. The NIHR Health Technology Assessment (HTA) programme has had a substantial

injection of funding to support clinical trials, both those it commissions and in responsive mode. The HTA have recently extended the remit of their responsive mode funding and will now fund pilot studies, feasibility studies, and other study designs which may not be randomised controlled trials but which will evaluate the effectiveness of interventions. The NIHR Programme grants and the NIHR Research for Patient Benefit funding streams are now well established and substantial amounts of funding are available for clinical research. Add to this the infrastructure support which is being established through the CLRNs, and there is real optimism that the amount and quality of clinical research in the UK will increase substantially over the coming years. Perhaps it is not surprising that it takes a while for such systems to "bed down", but once the processes are established, there will be a real opportunity to substantially expand activity in this area.

What are the implications of all these changes for the BAPM Clinical Trials Group?

The BAPM Clinical Trials Group needs to establish whether it has a role, and if so, what its role may be, in this radically changed environment. The Clinical Trials Group will be meeting later in 2008 to discuss their role, including whether they have a role. If you have views about the future of the Clinical Trials Groups, we will be grateful to hear them prior to our meeting. You can contact us via the BAPM website or contact Peter Brocklehurst at Peter.Brocklehurst@npeu.ox.ac.uk

Peter Brocklehurst

Financial Statements for the year ended 31 March 2008

Legal and administrative information

Charity name:	British Association of Perinatal Medicine	
Nature of governing document:	Deed of Trust establishing unincorporated charitable trust	
Charity registered number:	285357	
Trustees and officers:	Prof. N. Marlow Dr. A. Lyon (to September 2007) Dr. A.B. Gill (from September 2007) Dr. J. Ahluwalia	
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 October 2001 appointed those individuals who hold the offices of President, Secretary and Treasurer of the Charity as Trustees for a period of three years.	
Executive committee		
Officers of the association	Prof. N. Marlow	President
	Dr. A. Lyon	Honorary Secretary (to Sept 2007)
	Dr. A.B. Gill	Honorary Secretary (from Sept 2007)
	Dr. J. Ahluwalia	Honorary Treasurer
Paediatric representatives	Dr. A. Fenton	North of England
	Dr. M. Hall	South of England (to Sept 2007)
	Dr. J.Hawdon	South of England (from Sept 2007)
	Dr. J. Coutts	Scotland (to Sept 2007)
	Dr. P. Booth	Scotland (from Sept 2007)
	Dr. J. Moorcraft	Wales (to Sept 2007)
	Dr. J. Matthes	Wales (from Sept 2007)
	Dr. D.Corcoran	Ireland
Obstetric representatives	Dr. D. Peebles	
	Ms. K.Stanley	(to January 2008)
	Mr. W. Martin	
Nursing / Midwifery representative	Dr. A. Leslie	(to Sept 2007)
	Mrs A.Gibbs	(from Sept 2007)
Allied professions representative	Ms. C. King	
Executive officer	Ms. Lisa Nandi	
Principal office and charity address:	5-11 Theobalds Road, London, WC1X 8SH	
Independent examiners	Winston Fox & Co, Chartered Accountants 34 Arlington Road, London, NW1 7HU	
Solicitors	Capsticks Solicitors 77/83 Richmond Road, London SW15 2TT	
Principal bankers:	HSBC 117 Great Portland Street, London, W1W 6QJ	

Report of the Trustees

The Trustees present their report and accounts for the year ended 31 March 2008.

Principal Objectives and Aims

The British Association of Perinatal Medicine was established in 1976 and is governed by its Trust Deed (as amended by supplemental deeds dated 14 December 1992 and 25 October 2001) and its Constitution. The Charity was first registered on 5 August 1982, in accordance with the rules of the Charity Commission, and assigned Charity number 285357.

The Charity's aim is to improve perinatal care for pregnant women, newborn babies and their families. It achieves this by providing advice and information for Government, Medical Royal Colleges and other organisations; by facilitation of research and clinical trials; by education, training and information services for doctors and other health professionals and by auditing and monitoring of outcomes.

Structure and Organisation

A Deed of Trust establishing an unincorporated charitable trust governs the Charity. In accordance with the provisions included in the Deed of Trust, the Charity is under the overall control of the Trustees of the Association, who conduct the affairs of the Charity in conjunction with the Executive Committee (sometimes referred to as the Management Committee).

The Charity has an open recruitment procedure for new Trustees and Executive Committee members, who are nominated from among the membership and elected to office for a term of three years. The Charity is encouraging policies and procedures for the induction and training of both new and existing trustees and committee members. The maximum number of Trustees is three at present.

The Trustees and Executive Committee meet regularly to set the policy and overall direction of the Association, to review its plans and to discuss the management of the Charity's affairs. The Charity is under the overall control of the Trustees. The Trustees and Executive Officer undertake the day-to-day administration and supervision of services assisted by both paid and volunteer support staff.

The Deed of Trust and Constitution were under review by the Association's solicitors during 2007 to ensure that the needs of the Charity and its members are adequately met. The Annual General Meeting (AGM) in September 2007 considered possible changes resulting from this review and agreed that no changes were required.

Trustees

The Trustees, who served at the beginning and end of the year were as follows:

Prof. N. Marlow	President
Dr. A. Lyon	Honorary Secretary (to Sept 2007)
Dr. A.B. Gill	Honorary Secretary (from Sept 2007)
Dr. J. Ahluwalia	Honorary Treasurer

Executive Committee

The current members of the Executive Committee are listed on a separate page under legal and administrative information. The Executive Committee consists of the Trustees of the Association and Representatives elected from the membership, each of whom holds office for a period of three years. The representatives consist of five paediatricians, three obstetricians, one nursing/midwifery representative and one allied representative for allied professions and others. The Committee meets at least once between Annual General Meetings (AGM).

Membership

Membership is open to those who are engaged in practice, teaching or research into any aspect of perinatal medicine on nomination by an existing member. In addition, other individuals contributing to the advancement of perinatal medicine may be nominated for membership. Election to membership is confirmed by a two-thirds majority vote of the members present at the AGM.

Review of principal activities and developments

The objects and principal activities of the Charity are aimed towards improving perinatal care for pregnant women, newborn babies and their families. There were no significant changes to the objects of the Charity and its activities have continued during the year. The activities of the Charity have increased considerably over the last 25 years and it has developed collaborative links with a number of professional associations and parent organizations involved in the care of the mother, foetus and newborn. It is now a major sub-specialty group of the Royal College of Paediatrics and Child Health and a professional society of the Royal College of Obstetricians and Gynaecologists. It joins with the Royal College of Paediatrics and Child Health on setting standards of training for doctors within neonatal medicine and provides an annual educational meeting for trainees within perinatal medicine. A number of working parties exist to facilitate research and clinical trials and to develop national neonatal datasets. The Charity has contributed to the Continuing Professional Development of health professionals within perinatal medicine by providing postgraduate education conferences and meetings.

Financial review

The Statement of Financial Activities shows the summarised results for the year for the separately designated funds, both unrestricted and restricted. The total incoming resources amounted to £152,734 (2007: £152,411) and the total resources expended amounted to £115, 576 (2007: £129,948) resulting in net incoming resources of £37,158 (2007: £22,463), which have been transferred to the accumulated funds. The unrestricted funds have increased by £30,872 (2007: £17,027) to £154,388 (2007: £123,516), and the restricted funds have increased by £6,286 (2007: £5,436) to £128,921 (2007: £122,635).

The increase in the incoming resources arose mainly from membership subscriptions £74,800 (2007: £72,238) as a result of the increase in membership and in annual fees implemented during the year to 2007 for medical members to £100 from £75 and for non-medical members to £50 from £40, and also from the increase in income from sponsorship and exhibitors to £25, 015 (2007: £22,950). Income from events and conferences fell to £25,170 (2007: £31,682) due to lower attendance at the AGM conference, lectures and dinner.

The major sources of income for the unrestricted funds arose from members' subscriptions, non-specified donations, annual general meeting, events, sponsors and exhibitors. The main part of this income was utilised for office accommodation, salaries and general administrative expenses and to finance the various educational events, meetings and other activities of the Charity.

Reserves policy

The Trustees review the Charity's reserves policy at regular intervals during the year and after consideration of the annual financial statements and the budget projections of income and expenditure. The Trustees are satisfied that the current level of reserves is adequate to meet both unforeseen contingencies and the costs of the developmental activities planned for the next three years.

In order to maintain the current level of reserves, the Trustees are continuing to implement strategies to restrict any deficits incurred at the various meetings of the Association. Also, the proposed increase in the annual membership subscription was implemented for subscriptions receivable from 2007. The additional subscription income has been utilised to finance the increase in administration costs, which include staff and support costs and governance and strategy costs.

The Charity has restricted funds, namely the Library Fund and the Founders Lecture Fund. The Library Fund of £111,400 (2007: £106,376) is being accumulated for the establishment of a library of perinatal medicine to further the objectives of the Charity. The purpose of the Founders Lecture Fund of £17,521 (2007: £16,259) is to cover the expenses of the person who delivers the lecture each year at the Annual General Meeting, and the level of its funds is considered adequate for this purpose.

The unrestricted Educational Bursary fund is to provide educational bursaries for members of the Charity at the discretion of the Trustees. Donations and sponsorship received in the year amounted to £1,025 and the balance amounted to £3,827 (2007: £2,812). Awards amounting to £250 were made after the year end.

Risk management

The Trustees have conducted their own review of the major risks to which the charity is exposed and have established systems to mitigate those risks on an ongoing basis, ensuring that the Charity's needs are met and that there are adequate resources to enable it to continue its operation.

Investment policy

The Charity has powers under its constitution to make such investments as the Trustees see fit and which meet with the requirements of its objectives and various funds. The Trustees' policy is to invest funds and reserves in bank deposits and long-term bonds. The Trustees consider that the return on investments is satisfactory in the current economic climate.

Co-operation with other organisations and bodies (both charitable and non charitable)

From time to time, the Charity receives from and provides to other organisations within perinatal medicine tangible and intangible assistance for the furtherance of its objects. It also collaborates with other charitable and non-charitable organisations when considered necessary and in accordance with its objectives.

The Charity is grateful for the support given by these organisations whether financial or non-financial.

Statement of Trustees' responsibilities

The Charities Act 1993 requires the Trustees to prepare accounts for each financial period which give a true and fair view of the state of affairs of the Charity as at the balance sheet date and of the statement of financial activities for incoming and outgoing resources including income and expenditure for that period. In preparing those accounts, the Trustees are required to:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- prepare the accounts on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation; and
- state whether applicable accounting standards and Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the accounts.

The Trustees are responsible for maintaining proper accounting records which disclose with reasonable accuracy at any time the financial position of the Charity and to enable them to ensure that the accounts comply with the Charities Act 1993 and with the requirements of the Statement of Recommended Practice (SORP 2005) "Accounting and Reporting by Charities". 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.

This report was approved by the Trustees on 4th September 2008

Dr J S Ahluwalia
Trustee

Independent examiners' report to the Trustees

We report to the Trustees of the British Association of Perinatal Medicine (the Charity) on the accounts for the year ended 31 March 2008, which comprise the Statement of Financial Activities, the Balance Sheet and the related notes. These accounts have been prepared in accordance with the accounting policies set out therein and the requirements of the Financial Reporting Standard for Smaller Entities (effective January 2007).

This report is made solely to the Charity's Trustees, as a body. Our work has been undertaken so that we might state to the Trustees those matters we are required to state to them in an independent examiners' report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Charity and the Charity's Trustees as a body, for our work, for this report or for the opinion we have formed.

Respective responsibilities of Trustees and independent examiners

As described in the statement of Trustees' responsibilities in the Trustees' Report, the Charity's Trustees are responsible for the preparation of the accounts and they consider that the Charity is exempt from an audit for the year under section 43(2)of the Charities Act 1993 (the Act) and that an independent examination is required.

It is our responsibility to examine the accounts under section 43(3)(a) of the Act and to carry out procedures designed to enable us to report our opinion and to state whether particular matters have come to our attention.

Basis of independent examiners' report

Our examination was carried out in accordance with the general directions given by the Charity Commissioners and the requirements of the Act. Our procedures consisted of an examination of the accounting records, comparing the accounts with the accounting records kept by the Charity and making such limited enquiries of the officers of the Charity as we considered necessary for the purpose of this report. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently we do not express an audit opinion on the view given by the accounts.

Independent examiners' opinion

In our opinion:

(a) the accounts of the Charity for the year to 31 March 2008 are in agreement with the accounting records kept by the Charity under section 41 of the Act; and

(b) having regard only to, and on the basis of, the information in those accounting records, those accounts have been drawn up in a manner consistent with the provisions of the Act, so far as applicable to the Charity; and

(c) having regard only to, and on the basis of, the information in the accounting records, the Charity satisfied the accounting requirements of the Act for the financial year in question.

Winston Fox & Co
Chartered Accountants
34 Arlington Road
London NW1 7HU

Dated 5th September 2008

	Notes	Unrestricted Funds £	Restricted Funds £	Total funds 2008 £	Total funds 2007 £
Incoming resources	1				
Incoming resources from generated funds					
Voluntary Income					
Members' subscriptions		74,800	-	74,800	72,338
Donations		870	-	870	930
Educational bursary sponsorship		1,025	-	1,025	2,812
Gift aid receivable		15,315	-	15,315	11,685
Activities for generating funds					
Sponsors and exhibitors	3	25,015	-	25,015	22,950
Membership list, leaflets & inserts		295	-	295	639
Investment income					
Bank interest		4,261	5,983	10,244	9,375
Incoming resources from charitable activities					
Events and conferences	3	25,170	-	25,170	31,682
Total incoming resources		**146,751**	**5,983**	**152,734**	**152,411**
Resources expended	1				
Cost of generating voluntary income	4	4,301	-	4,301	4,644
Cost of generating funds	4	5,735	-	5,735	6,192
Charitable activities					
Events and conferences	4	45,020	543	45,563	52,429
Members' services	4	10,753	-	10,753	11,610
Other meetings	4	4,609	-	4,609	6,673
Advice and information	4	13,467	-	13,467	15,520
Governance & strategy costs	4	31,148	-	31,148	32,880
Total resources expended	4	**115,033**	**543**	**115,576**	**129,948**
Net incoming resources	2	**31,718**	**5,440**	**37,158**	**22,463**
Transfers between funds	10	(846)	846	-	-
Net movement in funds		**30,872**	**6,286**	**37,158**	**22,463**
Total funds at 1 April 2007	10	123,516	122,635	246,151	223,688
Total funds at 31 March 2008	10	**154,388**	**128,921**	**283,309**	**246,151**

There are no recognised gains and losses other than those in the statement of financial activities, and therefore no statement of total recognised gains and losses has been prepared. All incoming resources and resources expended derive from continuing activities.

Balance Sheet as at 31 March 2008

	Notes	£	2008 £	£	2007 £
Fixed assets					
Tangible assets	**5**		**1,404**		**2,273**
Current assets					
Debtors	6	55,278		41,192	
Cash at bank and in hand	7	261,902		243,717	
		317,180		284,909	
Creditors: amounts falling due within one year	8	(35,275)		(41,031)	
Net current assets			281,905		243,878
Total assets less current liabilities			283,309		246,151
Unrestricted funds					
General fund	9 & 10		154,388		123,516
Restricted funds	9 & 10		128,921		122,635
Total funds	9 & 10		283,309		246,151

The Trustees are satisfied that the Charity is entitled to exemption under Section 43(2) of the Charities Act 1993.

The Trustees acknowledge their responsibilities for:

(i) ensuring that the Charity keeps proper accounting records which comply with Section 41 of the Charities Act 1993; and

(ii) preparing accounts which give a true and fair view of the state of affairs of the Charity as at the end of the financial year and of its Statement of Financial Activities for the financial in accordance with the requirements of Section 42(1) of the Charities Act 1993.

Approved by the Trustees on 4th September 2008

Professor N Marlow
Trustee

1 Accounting policies

a ***Basis of accounting***

The accounts have been prepared under the historical cost convention, in accordance with the Financial Reporting Standard for Smaller Entities (effective January 2007) and in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities (2005) -(the SORP 2005).

b ***Incoming resources***

Incoming resources mainly comprise income from members subscriptions, sponsors and exhibitors, donations, events and conferences and are recognised in the period in which the income is receivable. These incoming resources are received for the general purposes of the charity and are included as unrestricted funds and used for general purposes.

Voluntary income is received by way of donations and gifts and is included in full in the Statement of Financial Activities when receivable. The value of services provided by volunteers has not been included.

Generated funds arise from sponsors and exhibitors at the annual general, trainees and clinical trials meetings and are recognised in the Statement of Financial Activities in the year to which they relate on a receivable basis and receipts in advance are carried forward to the period to which they relate.

Donations and grants for activities restricted by the terms of such income are included as restricted funds and used for the purposes specified as they become receivable.

Investment income is included in the Statement of Financial Activities in the year in which it is receivable.

c ***Resources expended***

Resources expended are recognised in the period in which the expenditure is incurred. Resources expended include attributable VAT which cannot be recovered.

Resources expended are allocated to the particular activity where the cost relates directly to that activity. Both staff and support costs have been allocated to each activity per accounting policy Note 1d below (see Note 4 for allocation).

d ***Staff and support costs***

These are management and administration costs and comprise expenditure not directly attributable to the generated funds, charitable or fund raising activities of the Charity, but relate to the furtherance of the charity's objectives. They are therefore allocated to the relevant category of resources expended based on estimates of the time devoted to each activity.

e ***Depreciation***

Depreciation on tangible fixed assets is provided over three years on a straight line basis in order to write off the assets over their estimated useful lives.

f ***Pensions***

The Charity operates a defined contribution pension scheme. Contributions are charged to the profit and loss account as they become payable in accordance with the rules of the scheme.

g ***Fund accounting***

Unrestricted funds are incoming resources receivable or generated for the furtherance of the objects of the Charity without a specified purpose and are available as general funds. Resources expended which meet these criteria are charged to the funds, together with a fair allocation of staff and support costs.

Restricted funds are used for the specific purposes laid down by the donor. Resources expended which meet these criteria are charged to the funds.

h ***Taxation***

The Charity is exempt from taxation on its charitable activities, as it is a registered charity.

2 Net incoming resources

	2008 £	2007 £
These are stated after charging:		
Trustees' fees and expenses	2,101	1,308
Depreciation of owned tangible fixed assets	869	984
Reporting accountants' fees for the year	2,820	2,879
Reporting accountants' fees for prior years	-	121
Trustees' indemnity insurance	2,340	2,247

Trustees fees and expenses
No fees or remuneration were paid to any of the Trustees during the current or previous year.

The Charity reimbursed Trustees' expenses as follows:	£	£
Prof. N. Marlow	587	453
Dr. A. Lyon	379	554
Dr. A.B. Gill	889	-
Dr. J. Ahluwalia	246	301
	2,101	1,308

3 Incoming resources

	2008 £	2007 £
Sponsors and exhibitors		
Exhibitors at events and conferences	4,515	5,700
Sponsors	20,500	17,250
	25,015	22,950
Events and conferences		
AGM, lectures and dinners	16,630	24,912
Clinical trials group meetings	2,395	1,660
Trainees' meetings	6,145	5,110
	25,170	31,682

4 Resources expended

a) Analysis of total resources expended

	Direct costs £	Staff costs £	Support costs £	2008 Total £	2007 Total £
Cost of generating voluntary income	-	2,909	1,392	4,301	4,644
Cost of generating funds	-	3,879	1,856	5,735	6,192
Charitable activities					
Events and conferences					
AGM, lectures and dinners	17,286	7,433	3,555	28,274	37,623
Clinical Trials meetings	6,305	1,363	652	8,320	6,223
Trainees' meetings	4,942	2,357	1,127	8,426	8,279
	28,533	11,153	5,334	45,020	52,125
Members' services	-	7,274	3,479	10,753	11,610
Other meetings	1,741	1,940	928	4,609	6,673
Advice and information	1,281	8,243	3,943	13,467	15,520
Founder lecture fee –restricted fund	543	-	-	543	304
	32,098	28,610	13,684	74,392	86,232
Governance & strategy					
Reporting accountants' fees	2,820	-	-	2,820	3,000
Trustees' indemnity insurance	2,340	-	-	2,340	2,247
Annual reports	2,254	-	-	2,254	2,465
Staff and support costs	-	13,090	6,262	19,352	20,895
Executive committee meetings	4,382	-	-	4,382	4,273
	11,796	13,090	6,262	31,148	32,880
Total resources expended	43,894	48,488	23,194	115,576	129,948

Staff costs and support costs are allocated to each category of resources expended based on estimates of the proportion of time spent in relation to the relevant activity.

b) Analysis of support costs

	2008 £	2007 £
Premises and office expenses		
Administrative services	11,007	11,516
Premises costs	8,002	8,268
Insurance	192	475
Computer costs / Website	94	110
Bank charges	471	909
Professional services	1,278	1,014
Legal services	-	4,700
General administrative costs	1,281	1,184
Depreciation	869	984
Total support costs	23,194	29,160

4 Resources expended (continued)

c) Analysis of staff costs

	2008 £	2007 £
Wages and salaries	40,547	40,342
Social security costs	3,886	3,844
Pension costs	4,055	4,051
	48,488	48,237

The staff costs relate to recharged expenses from the Royal College of Paediatrics and Child Health, which is a registered charity under number 1057744.

Average number of full time equivalent employees during the year		
Executive officer	0.8	0.8
Records co-ordinator	0.6	0.6
	1.4	1.4

5 Tangible fixed assets

	Presidential badge £	Computer equipment £	Total £
Cost			
At 1 April 2007	1,000	2,779	3,779
At 31 March 2008	1,000	2,779	3,779
Depreciation			
At 1 April 2007	-	1,506	1,506
Charge for the year	-	869	869
At 31 March 2008	-	2,375	2,375
Net book value			
At 31 March 2008	1,000	404	1,404
At 31 March 2007	1,000	1,273	2,273

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

6 Debtors	2008 £	2007 £
Unrestricted		
Fees and members' subscriptions	22,698	13,902
Gift aid tax receivable	26,166	20,700
Prepayments and accrued income	6,414	6,590
	55,278	41,192

7 Cash at bank and in hand	2008 £	2007 £
Restricted		
Dunn library fund	111,400	104,562
Founders lecture fund	17,521	16,451
	128,921	121,013
Unrestricted		
General fund	132,981	122,704
	261,902	243,717

8 Creditors: amounts falling due within one year	2008 £	2007 £
Expenses creditors and accruals	24,775	29,001
Deferred income	10,500	12,030
	35,275	41,031

9 Analysis of net assets between funds	Unrestricted Funds £	Restricted Funds £	Total Funds £
Fixed assets	1,404	-	1,404
Current assets	188,259	128,921	317,180
Current liabilities	(35,275)	-	(35,275)
	154,388	128,921	283,309

10 Movements in funds

	As at 1 April 2007 £	Incoming resources £	Resources expended £	Transfers between funds £	As at 31 March 2008 £
Restricted funds					
Dunn -Library fund	106,376	5,172	-	(148)	111,400
Dunn - Founders lecture fund	16,259	811	(543)	994	17,521
Total restricted funds (see note 11)	122,635	5,983	(543)	846	128,921
Unrestricted funds					
General fund	120,704	145,726	(115,033)	(846)	150,551
Educational bursary	2,812	1,025	-	-	3,837
Total unrestricted funds	123,516	146,751	(115,033)	(846)	154,388
Total funds	246,151	152,734	(115,576)	-	283,309

During the year, there were transfers between funds for interest received and expenses paid out.

11 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, the interest from which is used to remunerate the individuals who perform the lecture at the Annual General Meeting of the Charity.

12 Purposes of unrestricted funds

General fund
This fund represents incoming resources receivable or generated for the furtherance of the objects of the Charity without a specified purpose and are available as general funds for any of the Charity's purposes in accordance with its constitution.

Educational bursary
This fund represents donations and sponsorship to provide educational bursaries for members of the Charity at the discretion of the Trustees.

13 Financial commitments

	2008 £	2007 £
At the year end, the Charity had annual commitments under non-cancellable operating leases as set out below:		
Operating leases which expire in over five years:	8,215	8,215

Sponsors / Exhibitors / Advertisers

The following organisations support the activities of BAPM through sponsorship arrangements and we would like to thank them for all their support.

Abbott Laboratories
Abbot House
Norden Road
Maidenhead SL6 4XE

Central Medical Supplies
CMS House
Basford Lane
Leek, Staffs ST13 7DT

Chiesi Pharmaceuticals Ltd
Cheadle Royal Business Park
Highfield
Cheadle, SK8 3GY

Draeger Medical UK Ltd
The Willows
Mark Road
Hemel Hempstead HP2 7BW

Fisher & Paykel
16 Cordwallis Park
Clivemont Road
Maidenhead SL6 7BU

Infant Magazine
Stansted News Ltd
134 South Street
Bishops Stortford
Herts CM23 3BQ

Nutricia Ltd
Newmarket Avenue
White Horse Business Park
Trowbridge
Wiltshire BA14 0XQ

Orphan Europe
ISIS House
43 Station Road
Henley-on-Thames RG9 1AT

Philips Avent Ltd
Philips Centre
Guildford Business Park
Guildford
Surrey GU2 8XH

SLE Ltd
232 Selsdon Road
South Croydon
Surrey C22 6PL

Photographs courtesy of BLISS - the premature baby charity and Susan, Chris and Flora Mitchell

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