Annual Report 2011

BRITISH ASSOCIATION OF PERINATAL MEDICINE

Founded 1976

From the President

This is my last report as at this year's AGM I will have completed 3 years as President. The time seems to have gone very quickly and certainly it has been busy as BAPM has been involved in a wide range of activities and produced a number of new and revised documents. Alan will review our recent activity in his report as Hon Secretary but I would like to highlight here some themes that I hope will help us approach the challenges of the next 3 to 5 years. If there is one aspect of our work in the last 3 years of which I am particularly pleased, it has been the various measures we have put in place to increase involvement with the wider membership and also with related organisations. This has taken various forms:

- The volunteer panel of reviewers;
- Our regular network meetings;
- Wider membership involvement in our working groups;
- Establishing a trainees' group (as well as the trainees' education day) to develop both materials to attract students and trainees to neonatology and also to provide a forum for specialist neonatal trainees;
- Our closer relationship with some of the other specialist medical and nursing associations especially BMFMS.

Many of you will remember that it was in the President's report this time last year that I raised the idea of a more regular series of meeting with some of the other active specialist groups involved in perinatal care and in particular the British Maternal & Fetal Medicine Society, The Neonatal Nurses Association, The Scottish Neonatal Nurses Group, The Royal College of Midwives and the Obstetric Anaesthetists Association. We are at an early stage with our work/meetings but I believe we need to foster this collaboration (which I am pleased to say the other groups also appear to value). Through this group it should be possible to develop a truly perinatal view on issues facing our services. It is the intention of the member organisations to produce later this year a joint discussion document on the challenges facing high risk perinatal care in the UK.

However, in terms of neonatology, I think we as an Association need to go further. There is a desperate need for a voice that represents the broad consensus of neonatal opinion in order that those who need advice can have a genuinely broad based view. Whilst BAPM has made steady progress over a number of years in recruiting a range of members from other professional groups who work with the newborn or on neonatal units, the organisation is still predominantly medical. Even so, we have poor representation from those who work in either Local Special Care Units or Local Neonatal Units. It is these units that deliver the bulk of neonatal care in the UK. I think we have a task to increase our relevance to those who work in these settings. In terms of our members that are not medical, they are invaluable in broadening the perspective the Association can give to an issue. But we need more. In order to do this we need to make sure we meet the needs of those who might join and not simply offer them more of the same.

This leads me to the issue of the structure of our Executive Committee which has changed little in recent years and still is largely based on the model developed when the Association was first formed. The structure (for those who want the detail) is on the website. However there is geographical representation from across the UK in terms of neonatology. In theory this is also true of obstetrics but in recent years many obstetricians have been reluctant to accept this role and we have relied heavily on certain individuals (particular thanks are due to Bill Martin and Donald Peebles) most recently through cross representation with BMFMS and their Executive. On the other hand, we do not have a trainee representative and, despite the attempt to ensure geographical equity, we have no neonatologist on the Executive (or as a deputy) who works in London (or even the South East). We have just one deputy who works in a Local Neonatal Unit and no one from a Local Special Care Unit. The question I would like to pose is given that BAPM has six monthly meetings with the Neonatal Network teams across the country (including now Scotland and Wales) is geographical representation on EC still really needed, or would it be better to focus on having input from the different types of unit and the different types of personnel who work there? (Currently we do not have an active Advanced Neonatal Nurse Practitioner on EC). Personally I think the answer is yes, we do need to revise the structure of EC but this will need careful thought and debate over the coming months before any change in structure could or should be taken forward, especially since the existing structure has delivered a great deal over many years. I know that there is a range of views amongst EC members and there is no "preferred model" at this stage. There will be an opportunity to discuss this issue at the AGM: if you are unable to attend please send us your views.

I want to conclude by saying some "thank yous". Firstly, I want to thank all those members who have responded to our various calls for reviews or comments on documents or issues for which we have sought wider opinion. I have always felt more comfortable representing the position of the Association on an issue when we have first had the opportunity to gauge opinion amongst the membership. We really do take account of all comments and information we receive so please continue to take an active part in the Association. Secondly, I want to thank all the members and co-opted individuals who have been part of our various reviews groups/writing groups. This is not an easy job and takes time and effort but without your input we could not do the work we do. I also want to thank all the EC members I have worked with. They have given time and effort to help guide the Association through its various roles and all have helped shape our work. I have to thank in particular Bryan Gill and Alan Fenton who in their roles as Secretary during my time as President were the real face of the Association, and it is no small thanks to them that the standing of the Association continues to grow. The role of Treasurer is a somewhat thankless task but Mandy Ogilvy-Stuart has done an excellent job in steering our finances at a time when things have clearly been difficult as bank interest has shrunk away and companies pulled in their sponsorship.

Finally I want to say special thanks to Lisa and Hayley. I think other specialist Associations often envy the efficiency with which BAPM works and when asked why we are able to achieve what we achieve the answer is always an easy one – Lisa and Hayley. They really are what makes BAPM tick and so I am enormously grateful for all their support during my time as President.

All that remains is for me to wish Bryan every success as he takes on the role of President and I hope to see many of you at our AGM.

David Field

Objectives	Activities during 2010 -2011
Providing postgraduate education meetings throughout the year	• BAPM's Annual General Meeting held in September • The Perinatal Session of the annual Spring Meeting of the Royal College of Paediatrics and Child Health (RCPCH) • BAPM's Annual Perinatal Trainees' Meeting held in October • Perinatal Medicine 2011 conference (with BMFMS, NNA and Neonatal Society)
Facilitating clinical trials and other research	• Ongoing support and advice for those setting up and/or running perinatal clinical trials in the UK through active participation in: a) the Neonatal Clinical Studies Group (part of Medicines for Children Network) b) the Preterm Birth Clinical Studies Group (in collaboration with BMFMS)
Advising on training and education in perinatal practice	• BAPM's Annual Perinatal Trainees' Meeting held in October • RCPCH Specialist Advisory Committee (Neonatal Medicine) – setting competencies for higher specialist training and appointing to National Grid posts for Neonatal sub-specialty training • RCOG Specialist Societies Liaison Group
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**	Liberating the NHS: next steps on Maternity and Newborn Services in England Reference Group Perinatal Forum (with BMFMS, NNA, OAA, RCM and SNNG) Children's Clinical Advisory Group to the Payment by Results team NICE - Quality Standards consultation Tuberculosis: finding and treating hard-to-reach groups NPSA - Reducing the harm caused by misplaced nasogastric tubes Guidelines for the Investigation of Newborn Infants who suffer a Sudden and Unexpected Postnatal Collapse in the First Week of Life Joint Standing Committee consultation (between UK Newborn Screening Programme Centre and British Society for Paediatric Endocrinology and Diabetes) on rescreening preterm infants for congenital hypothyroidism RCOG Guidelines: Antenatal Corticosteroids to reduce Neonatal Morbidity NHSLA - Maternity Risk Management Standards Developing Neonatal Dashboards Bliss - 1-2-1 nursing campaign, staffing survey and Family Handbook Best Beginnings Breastfeeding Manifesto Coalition Maternity Care Working Party
Auditing and monitoring the outcome, structure and function of perinatal care for babies and their families	• Data working group (including revision of Categories of Care) • Neonatal Data Analysis Unit • National Neonatal Audit Project • Neonatal Network Clinical Leads, Nurses and Managers Group • Working group on Consultant Career Pathway for Neonatology • Working group on Community Midwifery Units (CMUs) • Working group on Communication with Trainees • Working group on Neonatal Organ Donation • Working group on Nursing Standards for QIS
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

The past year has seen the Association take on an increasing program of work and, importantly, this has resulted in many practical outputs. We have only been able to achieve and sustain this because of the involvement of an increasing number of members in various projects, coordinated overall by Lisa Nandi and Hayley Watts at the BAPM office. Members' participation has taken a variety of forms including commenting on consultation documents, being part of working parties and providing crucial feedback on a wide range of perinatal issues. Despite the rise in actively contributing members, there is still plenty of work to go around and I would encourage you to consider participating either in working groups or as part of the advisory group. If you are interested please contact Lisa or Hayley at the BAPM office with a brief summary of your background, special areas of interest and the contribution you feel you could make.

Recent working groups have reflected current 'live' issues for all professionals involved in perinatal medicine. Current working groups include one considering neonatal organ donation: we felt it timely to consider this area again but see it as a process of several stages. We need to establish which organs might or might not be suitable before considering the more practical aspects, including what might be possible to adopt in terms of existing practice in other countries and the legal and ethical barriers to such a change.

The framework document around neonatal support for stand alone midwifery units was produced in response to the increased interest in the provision of this service for low risk populations and the perinatal forum (the collaboration between BAPM, BMFMS, NNA, RCM, OAA and Scottish Neonatal Nurses group mentioned by the President) is examining service provision at the opposite end of the care spectrum. It is becoming clear that the way some aspects of perinatal care are delivered is likely to change radically

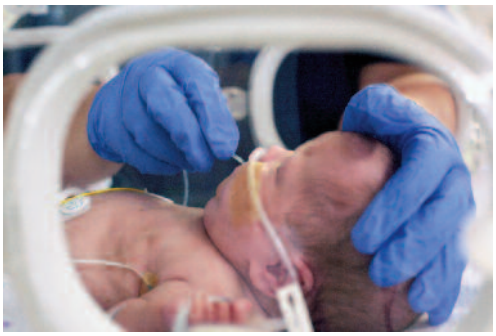
in the coming years and this will have significant impact on consultants' career pathways. This is likely to predominantly affect those at an earlier stage of their career and it was encouraging to see the level of interest from both recently appointed consultants and trainees in the consultant career pathway working group. The group considered the advantages and disadvantages of various options and further discussion is needed. Whichever models are adopted will be heavily influenced by numbers of trainees coming through the system and I am very grateful for the input we received from David Shortland (Vice President, Health Services, RCPCH). In terms of the neonatal grid the last round saw appointment of 33 candidates. The overall number of applicants remains high, which is encouraging for the speciality. Obviously the numbers of consultant vacancies will need to be commensurate with trainee numbers.

Current trainees are clearly the 'face of the future' for both the speciality and the Association and it is therefore essential that the work we undertake is relevant to their needs and interests and engages with them. We are focusing on trainee issues through the trainees' communication group, chaired by Gopi Menon and an informal 'So you want to be a Neonatologist' session at the RCPCH meeting

Honorary Secretary's Report (cont)

attracted an enthusiastic group of trainees and medical students. Half a dozen neonatologists took part in fielding questions and our feedback included the encouraging comments that not only were we enthusiastic and made the speciality seem attractive but we were also 'not in the least bit scary'! The BAPM annual trainees' meeting continues to be well attended and is high on audience participation; my thanks go to all those who contributed.

On the subject of meetings, Perinatal Medicine 2011 in Harrogate was very well attended. The distance between halls was in retrospect something that the President (hip replacement) and President Elect (knee replacement) might not have chosen given the option but otherwise feedback has been very positive! I hope that this meeting will continue to be part of our increasing interaction with BMFMS and we will shortly start the planning process for Perinatal Medicine 2014. In contrast, the perinatal group session at the RCPCH meeting in Warwick was far less well attended, despite being shared with the Paediatricians with Expertise in Cardiology Special Interest Group: I am conscious of the increasing clinical demands on members' time, competing meetings and reductions in study leave budgets. We need to consider the most effective way of delivering relevant continuing medical education in addition to providing a platform for research presentation. I believe our role in the RCPCH meeting needs re-evaluating and will need a different format if it is to continue.



Data collection and audit remain a major part of evaluating neonatal care. The categories of care have now been finished and should be on the website shortly. They will doubtless need revisiting to reflect changes in care modalities and pathways and will be key to any payment by results process. The data working group is presently considering descriptors for outcome measures including mortality, chronic lung disease, neonatal encephalopathy and developmental outcome. Many neonatal networks are developing dashboards, many of which are primarily used to simply 'count numbers'. We see the potential for developing these further whereby a small number of key performance measures might flag up potential problems at an early stage.

BAPM continues to host the twice-yearly neonatal networks leads meeting. Whereas EC meetings tend to consider 'general' policy, the networks meeting provides a forum for widespread discussion of 'live'

issues and information sharing or problem solving. Most recently issues addressed have included categories of care, developments within the National Neonatal Audit Programme, logistics and funding of transfers between networks, what constitutes an inappropriate transfer and nurse education in addition to feedback from meetings concerning 'Liberating the NHS'. We await the final outcome of the latter process with interest.

The use of high fidelity mannequins are being increasingly used in neonatal training and are seen as a way of providing 'point of care' simulation locally for multidisciplinary teams. It also has the potential benefit to address some of the constraints around exposure to certain conditions imposed by junior doctors' working hours as well as funding staff to attend external courses. As with all 'new' ways of delivering training it is clearly important that it is 'fit for purpose' and that the existing experience with this modality is not overlooked. We plan to include twice-yearly simulation training updates in the newsletter to help inform those running local programs and highlight links to recognised 'centres of excellence' and appropriate literature and new developments. Jonathan Cusack's update on simulation is on page 8 of this report.

Those of you who read all EC minutes carefully will have noticed that our longest-running agenda item is about to be concluded. Professor Peter Dunn very kindly established a fund to be used for the purpose of setting up a perinatal historical library to house his unique collection of perinatal resource material. This endowment appears as 'restricted funds' within the Association's annual accounts. After considerable negotiation we have finally reached agreement with the RCPCH as to where this is to be housed and Christine Cooper is taking responsibility for transferring the library from Professor Dunn to the RCPCH.

Finally I would like to thank certain individuals and groups for their support and encouragement during the last year. David Field has been a source of clear, wise thinking and I would also like to take this opportunity to thank him for all he has done for the Association during his tenure over the last three years. Lisa and Hayley in the BAPM office keep the Association running smoothly and make sure I keep on top of the work that comes my way. I am grateful for the time that EC members commit to helping the Association develop and to Mandy Ogilvy-Stuart for keeping our finances in check. I would also like to thank you, the members, for your involvement. I look forward to meeting many of you in London at the AGM.

Alan Fenton

Nursing and Midwifery update

This has been my first year as Nursing and Midwifery representative and I would like to start by thanking Alison Gibbs for all her hard work and commitment to the Association, and for the support she gave me in my time as Deputy. Can I also welcome Sandie Skinner from Winchester as our new Deputy Representative. We plan this year to update the 'nursing' section of the website – I would be happy to hear any thoughts or suggestions regarding what you would like to see included in this.

It has been a year of some uncertainty in terms of central financial proposals and the potential changes to the organisation of care within the NHS. Hopefully more recent developments supporting collaborative networks of care provision will continue – within our specialism we have certainly set a robust example for others to follow with strong partnerships and joint working relationships.

At the time of writing we are still waiting to see the full impact the new Skills Networks will have on specialised education commissioning for neonatal nursing. It will be vital to make sure our voice is heard in this arena if we are to maintain the standard of training we know is essential for this part of our workforce. It was with these potential changes in mind that in February of this year BAPM, in collaboration with the NNA and senior neonatal nurses from all interested parties in the UK, started work to create an essential core syllabus for QIS education pathways. This will map to the existing Scottish Neonatal Nurses Group 'Core Clinical Skills Set for neonatal nurses', which has been in use in all Scottish neonatal units for the last 6 years. The aim is to produce a standard of knowledge and skills that will be utilised as a tool to ensure consistency of competence at QIS level. It is planned for an initial outline of the work to be available at the November network leads meeting for comment and I am hoping for completion, following consultation with members, early next year.

Members have increasingly been reporting their concerns about the loss of senior clinical nurses, with some posts being 're-evaluated', meaning experienced neonatal nurses are being replaced by more junior or non-registered nurses. This is a very worrying situation, not only for the individual neonatal nurses involved, but also for the babies and families in our care. We may also see the negative impact of this on what is an ongoing problem - recruitment of numbers of nurses - with the potential for career development

being reduced. I have recently been working with Bliss with the aim of getting a clearer picture of what is happening in relation to this situation across units in England and hopefully the results of this survey will be starting to come in now.

As you know BAPM has a role in advising and commenting on many different aspects of perinatal care. Last year we invited members to put themselves forward as part of an advisory group for instances when we are approached for our views. Currently we have only a small numbers of nurses in this group and I would encourage those of you who have not already done so to consider this. The voice of nursing and midwifery is a very important aspect of the Association's work, so please contact Lisa if you feel you could contribute in this way.

I am sure those who attended the second Joint Perinatal Conference in Harrogate this year would agree with me that the event was excellent – I know my head was filled to overflowing by the end of the third day with the very high standard of talks and posters. I hope you found this both enjoyable and useful.

For me it is the multidisciplinary nature of BAPM and its aim to enhance the care of babies and families that is one of its greatest strengths. Our nursing and midwifery membership, as you know, has been fairly static but is, none the less, very important. So I would encourage all members to aim to nominate at least one new nursing BAPM member in the coming year. Please let me know if there are any other ways I can best represent you or if you have any issues you would like to see addressed. I look forward to seeing you at the AGM this year.

Sue Turrill

Professions allied to medicine

This has been a quiet year on the AHP front while we watched to see the joint effects of the national taskforce report and BAPM standards during this difficult financial period. We now have extensive documents outlining the role of AHPs within the clinical team on neonatal units, and for the vast majority of units this would mean an increase in the AHP establishment. On the other hand, we have trusts around the country who are struggling to keep within financial restraints and therefore unlikely to follow the recommendations of such reports where that would mean spending more money. The net effect seems to be little progress in provision of AHP support across perinatal networks and in individual units. However as far as it is possible to ascertain, there have been no or few losses.

Despite this frustrating situation therapists are progressing in establishing their roles within neonatology. This year has seen the publication of the Neonatal Physiotherapy Competencies (1). These have been put together by Adare Brady (Clinical Specialist Neonatal Physiotherapist, Lead Clinical Specialist Physiotherapist in Paediatrics Northern Health and Social Care Trust) & Peta Smith (Consultant Neonatal Physiotherapist, East Kent Coastal NHS PCT & East Kent Hospitals University NHS Foundation Trust) on behalf of the Association of Paediatric Chartered Physiotherapists Neonatal Group in May this year. The production of this highly informative and extensive document now leads the way for similar pieces of work by the other therapy groups. Other collaborative work has seen the updating of the Joint Consensus Statement on Weaning Preterm Infants which has been compiled by a group of neonatal dietitians and speech and language therapists. It is available on the dietitians' page of the BAPM website.

This will be my last annual report on behalf of the AHP group of BAPM. My time on the Executive Committee has been extremely informative and I have been privileged to see the incredibly hard work that goes into the running of the Association. Many thanks to Lisa Nandi and to the many Officers and representatives who have presided over BAPM during my time here, for their guidance and kind support. One of the main challenges which remains is how to encourage more therapists and other AHPs involved in neonatal care to join the Association, and it is hoped that some of the initiatives discussed over the last year may be tried and be successful. I will be handing over to Dr Jenny Kurinczuk, Director of the National Perinatal Epidemiology Unit in Oxford; she is also co-director of the Policy Research Unit in Maternal Health and Care. I wish her every success in her role as AHP representative.

(1) Brady,A & Smith,P. May 2011; A Competence Framework and Evidenced-based Practice Guidance for the Physiotherapist working in the Neonatal Intensive Care and Special Care Unit in the United Kingdom.

Caroline King

Neonatal Simulation Training - where have we been and what is on the horizon?

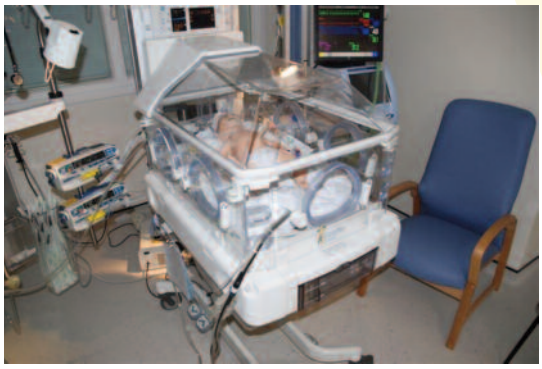
Simulation based training continues to gather momentum in neonatal units across the UK.

Simulation training has its origins in the airline industry, and is now extensively used to train pilots across the world. Training is focused on avoiding 'system failures,' and looking at the human factors that contribute towards error. The term 'Crisis Resource Management' has been used to describe some of these factors including communication skills, team working and leadership, role clarity and effective use of resources.

Neonatal high fidelity simulation training can be used to identify similar themes with the aim of improving patient safety and the quality of care that we deliver. The use of multidisciplinary high fidelity simulation training has been supported by the Chief Medical Officer and the National Patient Safety Agency. Sir John Templeton in his Department of Health commissioned report this year commented that simulation was ideally suited for 'accelerating the learning curve' and producing competent trainees within the time restraints imposed by the European Working Time Directive.

One of the key benefits of simulation based training is that it allows teams to repeatedly practice in a safe environment. This can help to identify gaps in knowledge, and uncover latent threats to patient safety, with the ultimate aim of improving team performance. There are a number of different types of simulation training that can be delivered. Mannequins have been designed to teach practical skills - most units will be familiar with those used to teach intubation and intravenous cannulation. More complex mannequins can be used to try to replicate a 'real clinical situation.' These high fidelity mannequins aim to create a 'total immersion' experience for trainees. Once the scenario is started, there is little input from the facilitator. In a well planned session, it is surprising how quickly trainees treat the situation as real and this provides insight into how teams work together. Complex scenarios can be developed using relatively basic mannequins as using a simple mannequin in a realistic looking environment can be surprisingly effective.

There are number of challenges in implementing successful simulation training programs. The Chief Medical Officer in his 2009 report 'Safer Medical Practice, manikins', machines and polo mints' felt that delivery of simulation training was piecemeal, and that there should be a focus on maintaining the educational quality of simulation training sessions.



Over the last 2 years, a national group of neonatologists interested in neonatal simulation has been established (www.neosim.co.uk) and national organisations including BAPM have realised the need to share resources and expertise. There have been two very successful national neonatal simulation meetings in Oxford and Leicester, and a further meeting is planned in Manchester in early 2012.

Simulation based training programs have been successfully run across a number of neonatal networks. There is a well established program that now runs across the East Midlands, and the East of England region has recently been successful in a bid to develop and run a similar 'point of care program' in all of the neonatal units in their region. These regional programmes are taking neonatal simulation beyond tertiary centres to all network hospitals. This is valuable as simulation based training is ideal for training teams in the early stabilisation of babies prior to transfer to a larger centre. Regional Simulation Centres continue to thrive with extensive simulation training occurring across the London Deanery, Oxford, Bristol and across the UK.

It is reassuring to see that there are well established programs for simulation faculty development, with some generic and some specific simulation instructor courses. This highlights the need for skilled educators to be able to deliver effective feedback to participants. Evolving feedback styles have led the Resuscitation Council (UK) to change how feedback should be delivered on their Newborn Life Support Courses.

The debriefing element of a simulation training session is the most critical part of the session: this is where most of the learning and reflection occurs. Educators are looking at the best ways to facilitate sessions, and there is an increasing amount of educational research looking at what factors in a session do most to enhance learning. The Centre for Medical Simulation at Harvard University is currently developing an assessment tool, to allow staff to

evaluate the quality of a simulation debrief: (DASH: http://www.harvardmedsim.org/debriefing-assesment-simulation-healthcare.php)
As simulation programs develop, it will be useful to have tools so that the quality of education delivered can be benchmarked and audited.

Medical staff do not work alone in the clinical area. It is important that as simulation programs develop, the training needs of the entire multidisciplinary team are considered. Some training programmes have tried to use a medical simulator to train large numbers of middle grade staff e.g. on registrar training days. Simulators can be used to teach practical procedures in a reproducible way. However, it is very difficult to learn about how a clinical team interacts together without involving nursing staff and advanced nurse practitioners.

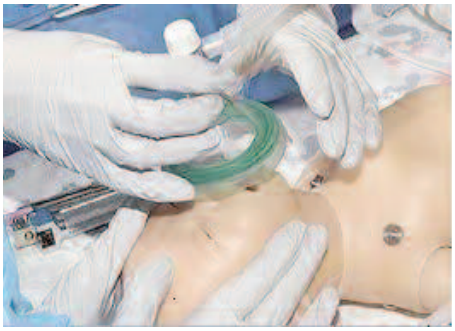
Research into simulation based education continues. Much of the research remains qualitative, although there are now papers emerging that demonstrate that simulation based training can improve a team's performance in the real clinical situation. It is important that this type of research continues. It is very difficult to demonstrate an improvement in clinical care after any educational intervention, but this should be our goal. Simulation based training remains costly, both in purchasing equipment and in staff time. Demonstrating the benefit of simulation based training is critical.

International groups such as the International Pediatric Simulation Society (IPSS: www.ipedsim.com) have been formed to encourage international research collaboration and sharing of best practice.

What is on the horizon?

Simulation training is developing rapidly and it is important to develop and maintain education partnerships, both within our own units and across neonatal networks. Simulation based education tends to be focused in tertiary neonatal intensive care units- it is important that this type of education is used in all units. It is perhaps more important for smaller neonatal units, where staff have less exposure to real critical events.

It is important that simulation based training does not evolve in isolation. High fidelity simulators are merely tools to enhance an education program.



Across the UK, simulation based training is being increasingly integrated into existing training programs. It is important that neonatologists maintain links with each other and with our general paediatric and perinatal colleagues as these simulation programs develop. In times of financial austerity, it is important that commissioners and Trusts continue to recognise the importance of simulation based education, and that training programs are resourced appropriately, both in terms of equipment costs and in senior staff job planning.

The national NeoSim group have recognised the need for, and have now started to develop an advanced neonatal resuscitation course. This is intended to complement local simulation based training programs, rather than to replace them and is an exciting development. Both the General Medical Council and the Nursing and Midwifery Council continue to support simulation based training. Simulation has not been fully evaluated as an assessment tool in neonatal education yet, but future use of simulators to assess and revalidate nursing and medical staff is inevitable.

Neonatal Units have embraced simulation as an educational tool, and is fantastic to see programs developing across the country. It is important to focus on the educational quality of sessions that are delivered and to encourage those just starting out: it is worth it!

Jonathan Cusack

BAPM Simulation Representative

Financial Statements for the year ended 31 March 2011

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. D. Field Dr. A.B. Gill (to Sept 2010) Dr. A.C. Fenton (from Sept 2010) Dr. A. Ogilvy-Stuart
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. D. Field	President
	Dr. A.B. Gill	Honorary Secretary (to Sept 2010)
	Dr. A.C.Fenton	Honorary Secretary (from Sept 2010)
	Dr. A. Ogilvy-Stuart	Hon Treasurer
Paediatric representatives	Dr S. Deshpande	North of England
	Dr. J. Hawdon	South of England (to Sept 2010)
	Dr. J. Eason	South of England (from Sept 2010)
	Dr. P. Booth	Scotland (to Sept 2010)
	Dr. G. Menon	Scotland (from Sept 2010)
	Dr. J. Matthes	Wales (to Sept 2010)
	Dr. S. Barr	Wales (from Sept 2010)
	Dr J. S. Craig	Ireland
Obstetric representatives	Prof. D. Peebles Dr. C. Alexander (resigned March 2011) Dr. M. Blott	
Nursing / Midwifery representative	Mrs. A. Gibbs (to Sept 2010) Ms. S. Turrill (from Sept 2010)	
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 2011.

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.

Review of principal activities and developments for the public benefit

The Trustees confirm that they have referred to the Charity Commission's general guidance on public benefit when reviewing the Charity's aims and objectives and in planning future activities and, in particular, how the planned activities will further its aims and objectives for the benefit of the public.

The Trustees review the Charity's principal aims, objectives and activities each year to ensure that the Charity remains focused on its stated purpose over the next 12 months for the promotion of education and research aimed towards improving perinatal care for pregnant women, newborn babies and their families. There were no significant changes to the main objectives and aims of the Charity during the year.

The activities of the Charity have increased considerably over the last 25 years and continue to include the following:

- Fostering fellowship and collaboration among those involved in the care of pregnant women, newborn babies and their families. It has achieved this by developing collaborative links with a number of professional associations and parent organisations involved in the care of the mother, fetus 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.
- Contributing to the Continuing Professional Development of health professionals within Perinatal Medicine by providing postgraduate education conferences and meetings.
- Facilitating clinical trials and other research. A number of working parties exist to facilitate research and clinical trials and to develop national neonatal datasets.
- Advising on training and education in Perinatal practice. 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 in Perinatal Medicine.
- Providing advice to Government and other professional bodies on developing and improving Perinatal care.
- Raising awareness of and proactively influencing the policy environment in which Perinatal care is delivered.
- Auditing and monitoring the outcome, structure and function of Perinatal care for babies and their families.

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).

Trustees Induction and Training

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 at the Annual General Meeting. The Charity is encouraging policies and procedures for the induction and training of both new and existing Trustees and Executive Committee Members and to familiarise themselves with the Charity and the context within which it operates, drawing the Trustees' attention to the Charity Commission website and publications signposted through the Commission's guide "Essential Trustee".

Trustees

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

Prof. D. Field	President
Dr. A.B. Gill	Honorary Secretary (to September 2010)
Dr. A.C. Fenton	Honorary Secretary (from September 2010)
Dr. A. Ogilvy-Stuart	Honorary Treasurer

The maximum number of Trustees is three at present. The Trustees received no remuneration during the year. A review of the Charity's activity during the year is included in the Annual Report

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 representative for allied professions and others. The Committee meets at least once between Annual General Meetings (AGM). The day to day management of the Charity has been delegated to the Executive Officer, Lisa Nandi.

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.

Risk Management

The Trustees have conducted their own review of the major risks to which the charity is exposed and have established systems and controls 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.

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 £135,643 (2010: £136,934) and the total resources expended amounted to £145,828 (2010: £136,900) resulting in net expenditure of £10,185 (2010: net incoming resources of £34), which have been transferred to the accumulated funds. The decrease in net incoming resources was mainly due to a drop in interest rates resulting in a fall in investment income and from an increase in costs due to a rise in expenditure on other meetings. The unrestricted funds have decreased by £11,781 (2010: decreased by £2,334) to £159,784 (2010: £171,565), and the restricted funds have increased by £1,596 (2010: £2,368) to £139,481 (2010: £137,885).

The increase in incoming resources from membership subscriptions to £77,000 (2010: £74,178) arose as a result of stable membership with fewer lapses. Income from sponsorship and exhibitors amounted to £12,203 (2010: £20,980) and the decrease arose due to fewer sponsors renewing their agreements while events and conferences income increased to £26,509 (2010: £21,940) from increased participants; this income reflects the gross amounts received from delegates and corporate sponsors before direct conference costs of £29,087 (2010: £32,417) and before allocation of wages and support costs of £12,351 (2010: £11,973) and £5,480 (2010: £5,308) resulting in a net deficit of £8,206 (2010: £6,778).

The major sources of income for the unrestricted funds arose from members' subscriptions, non-specified donations, Annual General Meeting conference, events, sponsors and exhibitors. The income was mainly 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 budgeted 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. The incoming resources are being 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 representing expendable endowments. The Library Fund of £120,768 (2010: £119,065) is being accumulated for the establishment of a library and archiving system of perinatal medicine to further the objectives of the Charity. In the event that the conditions for setting up the library and the archiving system are fulfilled, the donations will be utilised as restricted funds to meet the expenses in connection therewith. If the library is not established, this Fund is repayable to the donor. In 2011, the Trustees have continued to review the establishment of the library and archiving system as per the donor's specified requirements and this has been earmarked for establishment in 2011/12.

The Founders Lecture Fund of £18,713 (2010: £18,820) is utilised to cover the expenses of the person who delivers the lecture each year at the Annual General Meeting. The level of the funds is considered adequate for this purpose.

The unrestricted Educational Bursary fund is utilised to provide educational bursaries for members of the Charity at the discretion of the Trustees. Donations and sponsorship received in the year for the Educational Bursary Fund amounted to £nil (2010: £nil) and the accumulated fund amounted to £2,946 (2010: £2,946). No awards were made during the year.

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 objectives. It also collaborates with other charitable and non-charitable organisations when considered necessary and in accordance with its objectives.

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 7 September 2011.

Dr A Ogilvy-Stuart
Trustee

Independent examiner's report to the Trustees

I report to the Trustees of the British Association of Perinatal Medicine (the Charity) on the accounts for the year ended 31 March 2010, 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 April 2008 and in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities (2005) - (the SORP 2005).

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 opinion I have formed.

Respective responsibilities of Trustees and independent examiner

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 my responsibility to examine the accounts under section 43(3)(a) of the Act and to follow procedures laid down in the general directions given by the Charity Commission under section 43(7)(b) of the 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 Commission. My 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 the Trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a "true and fair" view and the report is limited to those matters set out in the statements below.

Independent examiner's opinion

In connection with my examination, no matter has come to my attention:

(a) which gives me reasonable cause to believe that in any material respect the requirements:
- to keep accounting records in accordance with Section 41 of the Act and
- to prepare accounts which accord with the accounting records and comply with the accounting requirements of the Act have not been met, or;

(b) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Anton J Winston FCA
Independent Examiner
Winston Fox & Co
Chartered Accountants
34 Arlington Road
London NW1 7HU

Dated 9 September 2011

	Notes	Unrestricted Funds £	Restricted Funds £	Total funds 2011 £	Total funds 2010 £
Incoming resources	1				
Incoming resources from generated funds					
Voluntary Income					
Members' subscriptions		77,000	-	77,000	74,178
Donations		-	-	-	750
Educational bursary sponsorship		-	-	-	
Gift aid receivable		16,145	-	16,145	14,286
Activities for generating funds					
Sponsors and exhibitors	3	12,203	-	12,203	20,980
Membership list, leaflets & inserts		-	-	-	-
Investment income					
Bank interest		2,040	1,746	3,786	4,800
Incoming resources from charitable activities					
Events and conferences	3	26,509	-	26,509	21,940
Total incoming resources		**133,897**	**1,746**	**135,643**	**136,934**
Resources expended	1				
Cost of generating voluntary income	4	5,300	-	5,300	5,135
Cost of generating funds	4	7,065	-	7,065	6,847
Charitable activities					
Events and conferences	4	46,918	150	47,068	49,933
Members' services	4	13,247	-	13,247	12,838
Educational bursaries		-	-	-	30
Other meetings	4	18,805	-	18,805	10,194
Advice and information	4	15,014	-	15,014	14,832
Governance & strategy costs	4	39,329	-	39,329	37,091
Total resources expended	4	**145,678**	**150**	**145,828**	**136,900**
Net incoming resources	2	**(11,781)**	**1,596**	**(10,185)**	**34**
Transfers between funds	10	-	-	-	-
Net movement in funds		**(11,781)**	**1,596**	**(10,185)**	**34**
Total funds at beginning of year	10	171,565	137,885	309,450	309,416
Total funds at end of year	10	**159,784**	**139,481**	**299,265**	**309,450**

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 2011

	Notes	£	2011 £	£	2010 £
Fixed assets					
Tangible assets	5		1,000		1,000
Current assets					
Debtors	6	29,818		28,147	
Cash at bank and in hand	7	290,283		308,499	
		320,101		336,646	
Creditors: amounts falling due within one year	8	(21,836)		(28,196)	
Net current assets			298,265		308,450
Total assets less current liabilities			299,265		309,450
Unrestricted funds					
General fund	10 & 11		159,784		171,565
Restricted funds	10 & 11		139,481		137,885
Total funds	10 & 11		299,265		309,450

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 year in accordance with the requirements of Section 42(1) of the Charities Act 1993.

Approved by the Trustees on 7 September 2011

Professor D Field
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 other 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 objectives 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

	2011 £	2010 £
These are stated after charging:		
Trustees' fees and expenses	5,290	3,486
Depreciation of owned tangible fixed assets	-	-
Reporting accountants' fees for the year	2,820	2,820
Reporting accountants' fees for prior years	540	-
Trustees' indemnity insurance	1,708	2,071

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. D. Field	1,782	1,540
Dr. A.B. Gill	1,562	1,611
Dr. A.C. Fenton	1,573	-
Dr. A. Ogilvy-Stuart	373	335
	5,290	3,486

3 Incoming resources

	2011 £	2010 £
Sponsors and exhibitors		
Exhibitors at events and conferences	753	480
Sponsors	11,450	20,500
	12,203	20,980
Events and conferences		
AGM conference, lectures and dinners	21,454	19,080
Trainees' meetings	5,055	2,860
	26,509	21,940

4 Resources expended

a) Analysis of total resources expended

	Direct costs £	Staff costs £	Support costs £	2011 Total £	2010 Total £
Cost of generating voluntary income	-	3,671	1,629	5,300	5,135
Cost of generating funds	-	4,894	2,171	7,065	6,847
Charitable activities					
Events and conferences					
AGM, lectures and dinners	26,117	9,378	4,161	39,656	41,878
Clinical Trials meetings	-	-	-	-	-
Trainees' meetings	2,970	2,973	1,319	7,262	7,820
	29,087	12,351	5,480	46,918	49,698
Members' services	-	9,176	4,071	13,247	12,838
Educational bursaries	-	-	-	-	30
Other meetings	12,791	4,166	1, 848	18,805	10,194
Advice and information	-	10,400	4,614	15,014	14,832
Founder lecture fee – restricted fund	150	-	-	150	235
	42,028	36,093	16,013	94,134	87,827
Governance & strategy					
Reporting accountants' fees	3,360	-	-	3,360	2,820
Trustees' indemnity insurance	1,708	-	-	1,708	2,071
Annual reports	3,005	-	-	3,005	1,767
Staff and support costs	-	16,518	7,329	23,847	23,108
Executive committee meetings	7,409	-	-	7,409	7,325
	15,482	16,518	7,329	39,329	37,091
Total resources expended	57,510	61,176	27,142	145,828	136,900

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

	2011 £	2010 £
Premises and office expenses		
Administrative services	14,029	11,745
Premises costs	8,962	8,681
Insurance	404	404
Computer costs / Website	231	716
Bank charges	1,086	981
Professional services	1,286	3,199
Telephone services	256	372
General administrative costs	888	189
Depreciation	-	-
Total support costs	27,142	26,287

4 Resources expended (continued)

c) Analysis of staff costs

	2011 £	2010 £
Wages and salaries	51,370	51,068
Social security costs	5,094	5,081
Pension costs	4,712	3,151
	61,176	59,300

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
Membership & Finance Assistant	0.8	0.8
	1.6	1.6

5 Tangible fixed assets

	Presidential badge £	Computer equipment £	Total £
Cost			
At 1 April 2010	1,000	2,779	3,779
At 31 March 2011	1,000	2,779	3,779
Depreciation			
At 1 April 2010	-	2,779	2,779
Charge for the year	-	-	-
At 31 March 2010	-	2,779	2,779
Net book value			
At 31 March 2011	1,000	-	1,000
At 31 March 2010	1,000	-	1,000

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	2011 £	2010 £
Unrestricted		
Fees and members' subscriptions	9,174	10,294
Gift aid tax receivable	14,656	14,250
Prepayments and accrued income	5,988	3,603
	29,818	28,147

7 Cash at bank and in hand	2011 £	2010 £
Restricted		
Dunn library fund	121,319	119,616
Founders lecture fund	18,863	18,820
	140,182	138,436
Unrestricted		
General fund	150,101	170,063
	290,283	308,499

8 Creditors: amounts falling due within one year	2011 £	2010 £
Unrestricted		
Expenses creditors and accruals	15,135	27,645
Deferred income	6,000	-
	21,135	27,645
Restricted		
Expenses creditors and accruals	701	551
	21,836	28,196

9 Analysis of net assets between funds	Unrestricted Funds £	Restricted Funds £	Total Funds £
Fixed assets	1,000	-	1,000
Current assets	179,919	140,182	320,101
Current liabilities	(21,135)	(701)	(21,836)
Net assets	159,784	139,481	299,265

10 Movements in funds	As at 1 April 2010 £	Incoming resources £	Resources expended £	As at 31 March 2011 £
Restricted funds (see note 11)				
Dunn - Library fund	119,065	1,703	-	120, 768
Dunn - Founders lecture fund	18,820	43	(150)	18,713
Total restricted funds	137,885	1,746	(150)	139,481
Unrestricted funds (see note 12)				
General fund	168,619	133,897	(145,678)	156,838
Educational bursary	2,946	-	-	2,946
Total unrestricted funds	171,565	133,897	(145,678)	159,784
Total funds	309,450	135,643	(145,828)	299,265

During the year, there were no transfers between funds for interest received and expenses paid out.

11 Purposes of restricted funds

Dunn – Library fund
This fund represents an expendable endowment arising from the capital sums received and treated as donations and also the cumulative interest arising from that capital. This fund is being accumulated by the Charity in accordance with the intention of the donor to eventually establish the Dunn Perinatal Library; to set up the Library and an archiving system to house the donor's collection of books, papers and slides; to make available these facilities to those individuals who are involved in the provision of Perinatal care in the British Isles. The specified condition of the donor is that in the event that the Charity should cease to exist or otherwise be unable to fulfil the purposes as set out above, then the endowment is to be returned to the donor or his beneficiaries in accordance with his wishes.

Dunn – Founders lecture fund
This fund represents an expendable endowment arising from the capital sums received and treated as donations and also the cumulative interest arising from that capital. This fund is being accumulated and utilised by the Charity in accordance with the intention of the donor to remunerate the individuals who give the lecture at the Annual General Meeting of the Charity in accordance with his wishes.

12 Purposes of unrestricted funds

General fund
This fund represents incoming resources receivable or generated for the furtherance of the objectives 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

	2011 £	2010 £
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:	20,312	20,312

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
Abbott House
Vanwall Business Park
Maidenhead
Berkshire SL6 4XE

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

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

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

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

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