Annual General Meeting of Australian & New Zealand Paediatric Nephrology Association

Held Friday 12th August 2016 at Royal Children’s Hospital, 50 Flemington Rd, Parkville, Melbourne

Minutes taken by Fiona Mackie in the absence of Tonya Kara

**Item 1:** Apologies: Tonya Kara, Chanel Prestidge, William Wong, Sally Kellet And Richard Kitching

Present: Josh Kausman, Deirdre Hahn, Amelia Le Page, Fiona Mackie, Swasti Chaturvedi, David Metz, Thomas Forbes, Harley Powell, David Mc Credie, Cathy Quinlan

Present via telephone: Sean Kennedy, Hugh McCarthy, Stephen Alexander, Anne Durkan, Peter Trnka, Sam Crafter, Nick Larkin, Elisabeth Hodson

**Item 2:** Confirmation of minutes. Minutes read and accepted as an accurate representation of 2015 AGM.

Proposed: Dee Hahn Seconded: Amelia Le Page

**Item 3:** Declaration of conflict of interest- nil expressed

**Item 4 a:** JK discussed the proposal for ANZPNA to become a chapter of ANZSN. He stated that previously although ANZPNA members have been on executive committees of ANZSN, there has been no mechanism to guarantee their presence. Therefore one of the major benefits of being formally included as a chapter would be to guarantee appropriate presence on committees.

The letter from Palo Ferrari, Chair of ANZSN was attached and discussed. ANZPNA would be an autonomous structure. The chair of ANZPNA would be given an Ex-officio seat and allowed voting rights and presumably better access to financial resources. The financial obligations on ANZPNA would not change and they would not be financially responsible for ANZSN. JK proposed that we accept these conditions for ANZPNA becoming a formal chapter of ANZSN. A former proposal for acceptance was made by Steve Alexander and seconded by Debbie Lewis. There were no views expressed against incorporating as a chapter.

The first meeting would be in Perth at the ANZSN meeting. JK is unable to attend and Dee Hahn will represent the chair.

***Action: JK will write to ANZSN and ask that ANZPNA will formally become a chapter of ANZSN. Dee Hahn will represent the chair at the inaugural meeting in Perth.***

**Item 4b: New ANZPNA website** JK congratulated Nick Larkins on the amount of work he had done on this. He is currently in the process of transferring previous data. Member contact details need to be updated. He is in the process of adding fact sheets and asking for relevant educational contributions.

SK discussed the fact that SPEC is looking at developing broader online educational resources via the ANZSN structure and website. He suggested not investing too much time in the development of these resources on our website until this has been done by SPEC.

SA suggested inserting a link to ANZSN on our website. SC will be an additional resource person for NL in assisting with the website.

JK suggested that the website needs better presence and suggested considering a working group particularly of younger members to think of ways of using the website and to raise the profile of the website.

**Item 4c – Trainee Travel Grants**. Blake Sandery was announced as the successful applicant for the all IPNA travel grants. The executive have previously discussed the issue of IPNA travel grants. The last travel grants were granted for 2013 Shanghai IPNA. There was only one applicant this year. It is proposed by the Executive that grants be made available for trainees to present at Paediatric Nephrology or transplant meetings either national or international. The first priority would still be to award IPNA travel grants, but if there is available funding then applications for other meetings could be considered. The maximum amount of money available was $6,000 over a 3 year period and the maximal amount to be awarded for a poster is $1,250 and $1,500 for an oral. Henceforth, the grants are to be known as the Paul Roy Travel Grants.

***Action: A statement should be formalised regarding the travel grants, amounts available and what is eligible and circulated. (TK)***

SK asked how to define a trainee and it was decided that a trainee would be defined as an associate member.

FM suggested a letter is sent to the widow of Paul Roy (Joyce Roy) to inform her about the commencement of the inaugural Paul Roy travel grant. This was supported by EH who stated it was an opportunity to highlight his contribution to Paediatric Nephrology in Australia.

***Action: Secretary of ANZPNA to send a letter to Joyce Roy informing her about the inaugural Paul Roy travel grant.***

**Item 5 – Nomination of New Members:** A number of associate members have now achieved full membership, Hugh McCarthy, Nick Larkin, Selma Torronen, and Anna Francis. These were proposed by D. Hahn, seconded by Amelia Le Page. A number of associate members were confirmed (see list). There are now 15 associate members. A number of senior members of ANZPNA who have made significant contributions to paediatric nephrology were granted honorary membership (will no longer be required to contribute fees). These were David McCredie, Andrew Rosenberg, Max Morris, Ken Jureidini, Elizabeth Hodson. Proposed by D. Han and seconded by Amelia Le Page.

***Action: TK to send letter congratulating these members on their honorary membership status.***

**Item 6 – Maintenance of Members Contact List** JK asked that members review this list and contact TK (secretary) if circumstances have changed. NL will coordinate this list with the website.

**Item 7 Chairs Report Presented by JK** – JK is pleased to have progressed the incorporation of ANZPNA as a chapter of ANZSN. He and other members are continuing to raise the profile of paediatric nephrology in Australia and in the region. Debbie Lewis was congratulated on her work with the Oceania project. The profile of genetics in Australia has been greatly increased by a number of members including Cathy Quinlan, Hugh McCarthy, Steve Alexander and Jeff Fletcher. Members are actively involved with College Educational Activities as well as transplantation allocation (FM) and histocompatibility committees (JK).

**Item 8 Treasurers Report –** DH presented the treasurers report. We are in a stable financial position. Most of the income is from members fees. 35 members are up to date with their payment. About two thirds of the membership took up combined membership with IPNA including six trainees. We have been able to reduce expenditure by using Barry Hodson as auditor. NL doing the website has also reduced are outgoing fees. It was requested that if you are taking up the combined subscription with IPNA that you pay by the deadline as all of these payments need to be submitted as an international transfer together. The issue of when to have the AGM was discussed by JK. It has to be held within 15 months of the previous AGM and there is a requirement for an audit to be done prior. So therefore it was suggested that we align our meeting with ANZSN. This particularly makes sense given that we are incorporating as a chapter at ANZSN. There was general support and agreement of members.

***Action: Further ANZPNA AGM’s will be held at the annual ANZSN meeting***

**Item 9 – Research Report –** PT presented this. The main trial is The Adopt which is in four paediatric and two adult sites. A number of future studies were discussed including a growth hormone outcome study and a qualitative transition study by Anna Francis.

**Item 10 – IPNA Report – Presented by DL –**A historical review of paediatric nephrology around the world is being coordinated by Rick Kaskell and he would like information on the history of Australian Paediatric Nephrology. It was agreed that EH would coordinate members, interview them and submit something by the end of the year. The next IPNA meeting is currently planned for Istanbul in 2019, but recent security issues mean that they may be changing the venue. IPNA has been discussing whether other countries are willing to volunteer as an alternative site for 2019. There was no expression of interest from Australia for holding the meeting in 2019. DL described the Oceania project. Very soon education and physical dialysis packs for commencement of dialysis for acute reversible AKI are to be distributed to some of the Oceania countries. A written information booklet to accompany the pack on insertion and commencement of dialysis was circulated and DL requested members to give feedback on the booklet directly to her. JK congratulated DL on her and the teams work on this project which should be up and running in the next couple of months.

**Item 12a College- Specialist Advisory Australia– presented by** AD. Projects have changed with one major report which can be a clinical project, systematic review or clinical audit to be submitted in the penultimate year. Book chapters are no longer acceptable as the major project; attendance of meetings is still mandatory. In terms of accreditation of sites for trainees, it has been proposed that the maximum time for a trainee to be spent in one site is increased from 12 to 18 months and that request was submitted to the specialist advisory committee. That will be submitted to the education committee and it is not expected to have an answer on that before the November meeting. Site accreditation was discussed as a number of sites will have their accreditation expire, but there will be an extension of 6 months given for those in who times running out.

**Item 12b College- Specialist Advisory New Zealand – report submitted by Chanel Prestidge.**

**Item 13 ANZSN Report –**

**Council Report submitted by JC**

**SPEC Report presented by SK** SK pointed out that SPECs major activity is designing the program for ANZSN. To date coordination of education has been fairly limited, but they are negotiating with council to increase the activities including recommencing a trainee weekend and also being involved with kidney school. ANZSN is looking at hosting a virtual training site and SK suggested that we may want to utilise this resource. Next year’s meeting for ANZSN is in Darwin in September. There was a discussion about the extent of the paediatric program and ANZSN. SK felt that there was a reasonable amount of paediatric content in the program, but we needed more paediatric members to actually attend the meeting before asking SPEC to expand the paediatric program.

JK expressed a desire to hold half day meetings for paediatric nephrology in association with ANZSN meetings. JK thanked SK for his contribution as a SPEC member as he is stepping down. PT expressed interest in taking over the SPEC role. JK proposed PT as the new SPEC member and this was seconded by EH.

***Action: JK to inform SPEC that PT will replace SK as paediatric member of SPEC***

**Item 14- TSANZ report presented by SA –** There was successful paediatric representation at the TSANZ meeting held in Sydney. Next year IPTA meeting is in Barcelona in May 2017. Paediatric priority for kidney allocation exists in New South Wales and Victoria. JK represents the paediatric group on histocompatibility committee and FM on the allocation sub committee. FM discussed the new KDPI index that is going to be given as information with all donor offers.

**Item 15 – ANZDATA Report – Presented by SK.** The issue of the paediatric form was discussed, is it a separate form and on it includes height and weight (critical for estimation of EGFR). It also has fields for educational attainments, many of which seem to be outdated and probably don’t fit every jurisdiction. AD has previously looked at the educational data submitted through ANZ data and less than a third has been completed. SK feels there is a need to revive and update the information. It is not clear what the barriers are to completing this information and is requested that members review these forms and discuss with the staff that complete these forms and provide feedback on them to the ANZ data committee or to members of the working group.

***Action: Heads of department are requested to discuss barriers to completion of paediatric ANZDATA form, especially educational attainment and feedback comments to ANZDATA members***

SK discussed the ANZDATA mechanism for researchers having priority of data. This is currently in the process of being formalised. Currently there is a 12 month reprieve period before data is given to another researcher, but there are moves to decrease that period to 6 months. There was a brief discussion regarding the identification of units presented in ANZDATA reports. SK suggested that JK have further discussion with heads of unit regarding whether units will agree to identification or not. SK raised the issue of consent on ANZ data. In New Zealand there is obligatory re-consenting when patient’s become adults. That has not been implemented in Australia yet, but is likely to be so in the future.

***Action: JK to contact HOD’s and have further discussion re decision on whether their unit’s data is to be identified in annual reports***

**Item 16 Genetics Report Presented by HMCC –** Formal renal, genetic clinics have been set up in Melbourne and Brisbane and are in the process of being set up in Sydney. Genetic testing is being expanded at Children’s Hospital, Westmead. JK congratulated him and the team on increasing the genetic profile in Australia. A genetics symposium is to be held on November 3rd to 4th organised by Cathy Quinlan at Royal Children’s Hospital, Melbourne.

**Item 17 – New Business**

1. JK raised the issue of voting rights at an AGM. The constitution defines voting eligibility through attendance at the meeting, but not as specifically face-to-face. Given the remote location of members across the society, the small number of members and need for a significant proportion of these members to remain in their units for service provision it should be accepted that attendance through teleconference fulfils the requirements for voting rights. This was accepted by the members present- LJ indicated that it was acceptable to minute and approve this clarification for the current meeting, but in order to formally approve this for future meetings it would need to be raised for a formal vote and approval with due notice at an AGM. JK proposed the acceptance of attending members through teleconference for the current meeting; seconded DL. This item to be raised for formal ratification at the 2017 AGM.

***Action- Draft motion for attendance via teleconference or video facility to be counted as attendance for the purposes of AGM. Motion will need to be circulated ahead of next AGM* RACP – new model for collaboration with Specialist Societies –** A skeleton model has been presented by the college. We don’t have an MOU with the RACP. JK has asked for input on the subject and will respond to the college in 4 weeks. Will also check with ANZSN has an MOU with RACP.

***Action: JK to ask ANZSN if they have an MOU with RACP***

1. **– Growth Hormone Application –** The process for growth hormone changed to an automated process and there was concern that this would now not allow for appropriate access in particular for younger infants with renal failure. Proposed new criteria had been attached and received favourably to date.
2. **Transition opportunity for new MBS funding -** AW has had discussions with MBS working group about providing for secured funding for multidisciplinary transition clinics; utilising an MBS item number. Due to the involvement of non-medical health providers this does not meet criteria through MBS, but received strong support in principle for this high risk group of CKD patients. There are possibilities for this to be pursued and AW will keep the members informed of any significant developments.
3. **Home Therapies Meeting to be held in Auckland – March 2018** – Anyone interested in contributing please get in contact with TK/ CP.
4. **Nephrotic Syndrome –** The nephrotic syndrome protocol for ANZPNA was discussed by JK. There has been a working group and numerous email discussions. 5 out of 8 units nominated the second protocol as first choice. Protocol 2 was the most popular when taking to account first and second preferences. One unit does not accept protocol 2. DH raised the fact that both the American Academy and the Indian Academy both had protocols of 6 weeks of daily Prednisone then 6 weeks alternate and then stopped and did not see why we had to have a different protocol to these two other major bodies. FM pointed out the fact that as option 1 was presented in the accompanying sheet there was some confusion about stopping versus tapering with Prednisone.

***Action: JK will email the units again and try and get further consensus. The major sticking point seemed to be abruptly stopping steroids versus tapering.***