THE PAEDIATRIC SOCIETY OF NEW ZEALAND

MINUTES OF THE ANNUAL GENERAL MEETING OF
THE PAEDIATRIC SOCIETY OF NEW ZEALAND
Held at the Palmerston North Convention Centre
On Thursday 22 November commencing at 4.35pm

Present:  
Dr Rosemary Marks  President
Mollie Wilson  CEO
and the following members:-

In attendance:  Denise Tringham

1  APOLOGIES
Jenny Corban, Brian Darlow, Annette Dickinson, Dawn Elder, Helen Evans, Stephanie Gapes, Dave Graham, Marianne Kayes, Elaine McCall, Ralph Pinnock, Liz Segedin, Dianne Webster.

2  MINUTES OF THE 2011 ANNUAL GENERAL MEETING
It was moved:-
That the Minutes of the Annual General Meeting of the Society held on 24 November 2011 are approved as a true and accurate record of that meeting.

Proposed Kevin Pringle
Seconded Anne Mitchell
Carried.

It was noted in future that members present at AGM’s will be listed.

3  MATTERS ARISING FROM THE MINUTES
No specific items were raised that were not covered in later business.

4  MEMBERSHIP (Total Membership 501)
4.1  New Members
Resolved:
That the following nominations, provisionally approved by Council since the 2011 AGM, be ratified as members of the Society:

Nicola Baird, Sally Birse, Jonathan Bishop, Patricia Bolton, Kay Boone, Arno Ebner, Jane Eyres, Janet Ferguson, Emma Glamuzina, Marc Grupp, Bianca van den Heuvel, Michelle Kane, Sandra Lanceley,
4.2 **Life Memberships Approved by Council since last AGM**

Resolved:

> That Michael Watt, provisionally approved by Council since the 2011 AGM, be ratified as a Life member of the Society:

Carried unanimously.

4.3 **Deceased Members since last AGM**

The following members, deceased since the last AGM, were observed and remembered:

David Holdaway, Percy Pease

5 **TREASURER’S REPORT**

The Treasurer’s Report for the year ended 31 March 2012 had been circulated and Rosemary Marks spoke to this.

5.1 **Main Society Accounts**

In the year ended 31st March 2012 the total income was greater than the total expenditure resulting in a net surplus of $184,248. The asset base at 31st March 2012 stood at $660,719 compared to the previous year of $474,285. This reflects funding received from the Ministry of Health Clinical Network Contract, including a component for the new Zealand Child & Youth Epidemiology Service, the Ministry of Health and Starship Children’s Hospital funding for the Kidshealth website, membership subscriptions, and Annual Scientific Meeting surplus.

Funding for the Kidshealth website remains vulnerable. No tender was accepted for the proposed Ministry of Health Online Child Health Information Service. The Paediatric Society of New Zealand Council funded the Kidshealth website for 2 months while potential funding options were negotiated and Starship Children’s Hospital has extended the current contract until 30th November 2012.

The surplus is largely attributable as follows:-

- MOH contracts – agreement was reached with the Ministry of Health to use the underspend for future Clinical Network contracts, diabetes, eczema and palliative care.
- Surplus from the 2011 ASM.

Revenue from annual subscriptions was $110,110 for the 2012 year which is an increase from the previous year’s revenue of $96,235.

It was moved:

> That the audited accounts of The Paediatric Society of New Zealand Incorporated for the year ended 31 March 2012 be accepted.

**Proposed**

Rosemary Marks

**Seconded**

Kevin Pringle

Carried unanimously.
5.2 **Travelling Trust**
The asset base as at 31st March 2012 was $110,535 which is a decrease from $118,764 the previous year. This largely reflects the Travelling Trust Scholarships totaling $4,969 awarded in the 2012 financial year. In addition a $2,186 (including GST) grant was provided to the Paediatric Society of New Zealand to cover a shortfall in funding from the Ministry of Foreign Affairs and Trade in the 2012 year.

Rosemary Marks reported there were detailed discussions at the recent face to face meeting of Council and SIG Chairs regarding the future of the Travelling Trust. It was agreed the assets of the Trust need to grow. If we continue to distribute the income of the Trust annually and the amount of the capital remains the same then the real value of the Trust is reducing. A two-level approach would be ideal, a cash fund to ensure funds are available for he scholarships, and a long term investment approach to ensure the on-going viability of the fund. A small working party will be set up in the new year to look the management of the Trust. It is anticipated at the AGM in 2013 some options will be put to the membership to consider.

It was moved

_That the audited accounts of the Paediatric Society Travelling Trust Fund for the year ended 31 March 2012 be accepted._

Proposed  Rosemary Marks  
Seconded  Barb Bradnock  
Carried unanimously.

5.3 **Annual Subscriptions**
It was moved:

_That there be no change to the annual subscription rates for the year 1 April 2013 to 31 March 2014._

Proposed  Rosemary Marks  
Seconded  Andrew Marshall  
Carried unanimously.

5.4 **Appointment of Auditor**
Discussion took place on the cost of auditing the accounts of the Travelling Trust and it was noted that the quotation received for audit of the Trust’s accounts is approximately 3% of the value of the Trust. The question was asked whether Travelling Trust audited accounts were necessary. It was agreed to suspend a decision on the audit of the Trust until after the review by the working party.

It was moved:-

_That KPMG be appointed Auditor to the main accounts of The Paediatric Society of New Zealand Incorporated for the year ending 31 March 2013._

Proposed  Rosemary Marks  
Seconded  Russell Wills  
Carried unanimously.

It was moved:-

_That the Executive will bring together a working party to review the Travelling Trust including the Trust Deed, the option of charitable status and the way the Trust should be financially managed in the future. By 31 March 2013 the working party will bring back_
Proposals to Council and if necessary a vote will go to the membership.

Proposed Rosemary Marks
Seconded Jeff Brown
Carried unanimously.

6 PRESIDENT & CEO REPORTS
6.1 President's Report

The President's report had been circulated and Rosemary Marks spoke to this.

2012 has been a year of mixed fortunes for child and youth health and for the Paediatric Society of New Zealand.

There have been some good “wins” despite the difficult economic climate. These “wins” include:

- Changes to the road rules and rise in the age of required use of child restraints improving child safety
- Media coverage of child poverty was important in bringing about some change. However there is a long way to go – not least of these is having a definition of child poverty which is clearly understood by all New Zealanders
- The White Paper provides a strong focus on child protection. There are omissions and some of the proposals will be challenging to implement. However the White Paper does provide a foundation on which to build cross sectoral approaches throughout New Zealand. We should therefore welcome this initiative and seek to develop it for the good of all New Zealand children and young people.

There have also been disappointments:

- The decision not to proceed with mandatory fortification of bread with folate was extremely disappointing.
- Communication within the sector remains challenging. The report on Behaviour Support Services for people of all ages with disability was notable for the failure to consult with Child Health Professionals. Dissemination of the report within DHBs meant that many did not receive it from appropriate channels.
- The PHARMAC decisions on insulin pumps and the application process resulted in considerable stress for Paediatricians and Nurse Specialists managing children and young people with type 1 diabetes.
- The Named Patient Pharmaceutical Application (NPPA) process which has replaced the Exceptional Circumstances scheme proved very frustrating for clinicians; we are awaiting a response to our letter to PHARMAC on these last two issues.

Around the country, the major centres had things to celebrate. Christchurch members, still adjusting to the “new normal” had good reason to cheer when approval and funding of the extensive new building programme was announced by government. Christchurch clinicians and managers have been working on this project for some years and the Society congratulates them for their achievement. We are all more aware now of how vulnerable the country is to seismic events and we strongly support the development of Christchurch as the South Island hub for tertiary services.

Wellington celebrated 100 years of providing child health services by hosting
the annual General Paediatric Update and it was heart-warming to see Capital and Coast DHB strongly supporting their celebrations in March.

Starship has also celebrated its 21st birthday this month, with a ball for staff last Saturday. A book celebrating the children and young people and their families who have used Starship services over the years will be published soon.

Society members are active in a wide range of areas, and I have listed many of those who contribute later in this report. For the executive and Council the major focus has been the implementation of the Clinical Networks contract, which Mollie Wilson, CEO will address more fully in her report.

We have also started work on formalising the Society’s policies and procedures; these will be placed on the website as each policy is completed and approved by Council. We hope that these will be a useful reference for members.

Our membership has continued to grow and following my challenge to Council in July we have achieved our goal of over 500 members. (Actual current membership 501). We now have 22 Special Interest Groups.

Clinical Networks
During 2012 the Advisory Group [CYNet, formerly the National Child and Youth Clinical Network Advisory Group (NCYCNA)] continued to meet monthly by teleconference, with face to face meetings every third month. Terryann Clark resigned early in the year as a result of a heavy workload and competing commitments. We welcomed Simon Denny, Youth Health Specialist based at Counties Manukau DHB, and Shaz Iseli, Clinical Team Leader/Manager in a primary care setting: the Cafe for Youth Health, Taupo.

The major piece of work this year has been discussing the future structure for ongoing support of Child and Youth Clinical Networks with the Ministry of Health. This has been a slow process and is ongoing

The initial networks are all making steady progress:
- Child Protection; Clinical Leader Patrick Kelly
- Paediatric Palliative Care: Clinical Leader Ross Drake
- Eczema; further development led by Diana Purvis and Debbie Rickard
- Type 1 Diabetes; further development led by Craig Jefferies and Barry Taylor

Strategic relationships
Regular monthly meetings have continued with National Health Board staff, to ensure work on national services and the clinical networks project is aligned.

PSNZ also has two nominees on the New Zealand Committee of the Division of Paediatrics and Child Health of the Royal Australasian College of Physicians (currently myself and David Newman, President Elect). A memorandum of understanding is in place and we are looking at ways that we can work more collaboratively with the RACP especially in relation to advocacy.

The appointment of Russell Wills as Commissioner for Children has led to strengthening of the working relationship with the Commissioner’s Office. The Society has entered into a partnership with the Office of the Children’s Commissioner to develop the Child and Youth Health Compass, based on the PSNZ Scorecard from 2002-2004. Like the Scorecard, the Compass is a bottom-up, clinician-led process to identify good practice in the planning and
delivery of services for children and young people and to share innovation and good practice. At the time of writing, the Compass steering group has chosen six domains to focus on in 2013, each with a chair and dedicated band of workers. It is intended that the questionnaire will be sent to DHBs in time to inform the 2013-2014 DHB planning cycle.

**New Zealand Child and Youth Epidemiology Service**

Dr Liz Craig has put together an impressive team in Dunedin and has continued to develop the service in the face of a challenging economic climate. A further successful DHB workshop was held in Wellington in May. NZCYES has an important role in supporting the development of Clinical Networks with robust information that can inform prioritisation. The NZCYES steering committee will be meeting in Auckland in mid December to assist Liz with charting the direction for the coming year.

**Kidshealth Website**

Members will recall that at the last AGM we were awaiting the outcome of the proposal to provide an Online Child Health Information Service as a Joint Venture with the Royal New Zealand Plunket Society and DraftFCB. Neither our proposal nor the other shortlisted proposal were accepted and the future of the Online Child Health Information Service remains uncertain.

However, the Ministry of Health has continued to support the kidshealth website, and PSNZ has continued to hold a contract with ADHB for Katherine Lissienko’s services as website editor. The website rebuild has been completed and went online on 27 June 2012. YouTube has been used to provide video content on the site.

**Telepaeds: NZ Telehealth Trust (formerly NZ Telepaediatric Trust)**

The Society has three nominated trustees on the Board of the New Zealand Telepaediatric Trust. The current PSNZ nominated trustees are Katherine Lissienko, Mollie Wilson and myself. Other Society members who are also trustees are Mike Sullivan (Deputy Chair), Karyn Bycroft, John Garrett and Roger Tuck. The other trustees are Peter Ross, Chair, Brian McMath and Amanda Oakley, dermatologist from Hamilton with a strong interest in clinical application of telehealth technology. Peter and Brian bring a business perspective to the Board which is invaluable. The Trust meets in alternate months by teleconference.

**Listserver and Website**

The website contains a wide range of information on the Society and its activities. The listserver continues to be an informal and informative channel for communication for members. As well as being useful for disseminating information about events and conferences of interest, the listserver provides a forum for lively discussion.

**Media Relations**

Media relations work continues at a variable rate. It is not clear what the impact of media coverage is on promoting the aims of the Society and advancing the interests of healthy children and young people.

**Submissions**

We have made a number of submissions on a range of issues. Through these submissions the Society can promote the interests of children and young people in the health sector. A complete list of public submissions can be found on our website. Some submissions are deemed more appropriate to the members’ section of the website and can be found under Discussion Papers.
The following members were acknowledged for their hard work on important aspects of the Society’s work:

- Andrew Marshall - spokesperson on folate fortification of the food supply
- Phil Pattemore – spokesperson on the issue of smokefree environments
- Innes Asher whose work for the Child poverty Action Group complements the efforts of the Society

Representation
The Society is often offered the opportunity to have representation on various Boards, Committees and Advisory Groups. Many members are active in other areas in other capacities extending PSNZ networks broadly across child and youth health. A summary of the wide range of activities that PSNZ members are involved in is appended to this report and it would be useful to try and maintain a record of members’ involvement in these activities.

SIG Activities
The SIG Chairs work hard to keep the members of the various Special Interest Groups informed and provide important support and to the Executive and Council in preparing submissions and representing the interests of children and young people in New Zealand.

Planned Activities for 2013
- Work on ensuring sustainability of Clinical Networks will be a major focus for CYNet
- Kidshealth
- Transition president elect, David Newman, with formal handover at 2013 AGM in Dunedin.

6.2 CEO’s Report
The CEO’s report had been circulated and Mollie Wilson spoke to this. The objectives of this position are:
1. To work with President, Council and membership to develop the concept, deliver the contract requirements and implement national clinical networks (CN) for children and youth
2. To provide support and seek sustainable funding for New Zealand Child and Youth Epidemiology Service (NZC&YES)
3. To represent the Society at nominated events and support the operations of the Society.

Clinical Networks
The contract between Paediatric Society of New Zealand (PSNZ) and Ministry of Health (MoH) is in the final quarter of its third operational year. Four meetings have been held during 2012 with MoH staff to seek approval for the development of two new CN within the current year and to confirm the PSNZ contract for 2013. At 16 November MOH advised PSNZ that a Business case had been forwarded to MOH senior management team for future funding consideration. The outcome of this proposal has not yet been confirmed.

Four Clinical Networks
PSNZ was tasked with selecting and implementing approved national child and youth CNs. These are; Child Protection; Treatment of Childhood
Eczema; Treatment of Children and Youth with Diabetes; and the Treatment of Paediatric Palliative Care. Accordingly, a comprehensive selection process and a suite of actions were undertaken.

In summary, the four CN have achieved most of their time-bound objectives or these continue to be 'work in progress’. At the request of MoH, a survey to seek feedback from stakeholders (within current clinical networks) was completed mid 2012. Overall, there was general satisfaction with developments to-date and a report was prepared and submitted to MoH and the Advisory Group.

Andrew Marshall asked about the future of additional work streams. Rosemary Marks advised that part of the work plan during 2012 was to look at two further networks going forward. Six proposals were put forward and the Advisory Group reviewed these and recommended that two should proceed straight away and that two further networks should proceed should we get a contract in 2013. We are currently still awaiting approval from the Ministry of Health. However the Ministry did indicate they would be happy for us to begin proceeding with the Newborn network. In our future discussions with the Ministry we will be talking to them about needing a quicker turnaround to proceed. It will be important going forward to have stronger links with what is happening regionally with what is happening nationally.

**Kidshealth**

The sustainability of Kidshealth is viewed as an important element in the suite of ‘networked services' provided for children, youth, families and health professionals. Following a MoH request for a proposal (mid 2011) for an Online Child Health Information Service, a joint venture (JV) was registered by PSNZ, Plunket and Draft FCB. In early 2012, MoH advised the JV partners that the proposal was the preferred model however, due to funding constraints MoH would not progress the contract at that time. In mid 2012, PSNZ/Kidshealth re-entered discussions with MoH to develop a stage one, confined topic pilot, for the Online Child Health Information Service.

Kidshealth funding. MoH extended the (previous) contract for a six-month period (e.g. June – November 2012) while the parameters of the specified pilot topic were discussed and agreed. In October 2012, MoH proposed a further extension of seven months to the current contract. MOH funding will now be carried forward to 30th June 2013. The MoH is currently drafting Service Specifications for this extension to core Kidshealth business.

During the past 12 months, positive discussions have been held with the Starship Foundation CEO regarding long-term support for Kidshealth’s 6 – 15 year age band. This continues to be a ‘work in progress’.

**NZ Child and Youth Epidemiology Service**

The MoH/PSNZ contract continues to fund a national annual NZC&YE Report. The NZC&YES Director has contributed to discussions with some of the national CNs CRG. These discussions focused on data/ information available on the relevant sub specialities. Due to coding variations, and the manner in which outpatient data is collected and collated, it is too early to extract specific information on these specialities; however, efforts will continue to try to extract meaningful information in the future.
Along with the PSNZ contract, the MoH team is considering where the national, annual NZC&YES Report(s) fit in future planning.

This twelve month period of work has been busy and productive. Based on observation of other national and international projects and MoH objectives, the tasks undertaken by PSNZ and the identified path going forward align to best practice and will support improvements in the health of New Zealand’s children and youth.

7  FUTURE ANNUAL SCIENTIFIC MEETINGS


Pam Jackson updated the AGM on preparations to date and advised three international speakers have already agreed to present.

7.2 2014

If we continue with our rotation of large centre small centre then it will be a small centre in 2014. Hawkes Bay hosted an ASM in 2000 and they had agreed to organise 2014. Convenor is yet to be determined.

8  REMITS – Child Passenger Safety

A draft proposed remit/position paper covering child passenger safety, put together by the Injury Special Interest Group, had been circulated and Julie Chambers spoke to this.

The meeting discussed the draft document and it was agreed this is a complex area. After discussion it was agreed to delete the last sentence in Clause 3.1 “Child restraints should be available for use whilst children travel in private cars, ambulances, shuttle buses, buses and taxis.”

The proposed remit, including the amendment above proposed by Julie Chambers and Kevin Pringle reads:-

1. The Paediatric Society of New Zealand believes that:
   1.1 Child passenger injury from road traffic crashes is a leading and preventable contributor to paediatric trauma mortality and morbidity in New Zealand. [1]

   1.2 All appropriate legislative, administrative, social and educational measures should be taken to protect children from injury, neglect, or negligent treatment while they are in the care of parent(s), or other caregivers. [2]

   1.3 The technical effectiveness of correctly used child car restraints is well proven. Properly fitted and correctly used child car restraints prevent injury and save children’s lives. [3]

   1.4 All child passengers travelling in motor vehicles, including those with special health needs, have the right to be kept safe. [2]

   1.5 Successfully promoting the correct use of child restraints requires appropriate legislation and its enforcement, distribution schemes that provide widespread access to affordable products, coupled with education campaigns delivered in conjunction with hands-on assistance for the correct fitting and use of the child restraints. [4-7]

   1.6 New Zealand’s health services must work in partnerships to ensure parents, caregivers, families/whānau, organisations, and government agencies all receive informed advice on the most effective ways to prevent child passenger injury. This
includes monitoring child passenger injury incidence, creating and distributing data and research on child passenger injury, and providing families who access health services with information and advice on their correct use of child car restraints and the safest seating positions for their children in vehicles. [6, 8, 9]

2. The Paediatric Society of New Zealand notes that:
   2.1 On average, each month in New Zealand one child younger than nine years of age is killed and eight more children are injured seriously enough to be admitted to hospital for overnight or longer, as a result of motor vehicle passenger injury (2004-2008). [10]

   2.2 Correctly using the appropriate car restraint for a child's age, height and physical proportions has been shown to reduce the risk of child death in motor vehicle crashes by between 47% and 80%. [3]

   2.3 Measuring the prevalence of correctly used child restraints is essential for effectively planning and promoting child restraint use. Regional surveys carried out in 2005 and 2009 found that between 45% and 65% of New Zealand families with children younger than five were not using restraints correctly. A 2011 Ministry of Transport survey showed that 71% of children aged between five and eleven were using an adult seat belt only, despite best practice advice that they should be seated in a booster seat. [8, 11]

   2.4 New Zealand has established a competency based certification process for Child Restraint Technicians that is part of the National Qualifications Framework. Certificated Child Restraint Technicians are available across the country and can provide face to face, informed advice about the correct fitting and use of child restraints. (accessed October 2012) [12]

   2.5 The designs of semi-reclining child restraints can put infants at risk of respiratory compromise. Newborn, preterm and term infants are at risk of oxygen desaturation when left sitting in semi-reclining child restraints. [13, 14]

   2.6 Seating position in the vehicle and the way the restraint is used are important factors for reducing injury risk. These include:

   a. Young children seated in forward facing car restraints can experience excessive cervical spine stretching or separation due to their relatively large head mass and anatomical differences to adults. The use of rearward facing seats for as long as practical reduces the incidence of these types of injury. [15]

   b. Children graduating into adult seat belts before they are tall enough (148 cms) to obtain the full safety benefits of the adult seat belt are at higher risk of injury than those who continue to use a restraint or booster seat. The majority of children do not reach 148cms in height until age of eleven. [16, 17]

   c. Children restrained only by a lap belt are at increased risk of sustaining abdominal and/or lumbar spine injuries (seat-belt syndrome) during a collision. Newer vehicles are equipped with three-point lap and diagonal seat-belts in all seating positions to prevent this injury. [3, 18]

   d. Children seated in a restraint in the front seat of a vehicle are exposed to the risk of serious injury from airbag deployment. All children younger than fourteen years old should be seated in a back seat. [19]

2.7 Child restraint legislation is used by the community as a guide to indicate what is required. When legislation does not match manufacturers' recommendations and
research, other initiatives are required. Programmes to promote the correct use of child restraints are most effective when delivered in conjunction with product distribution, education and hands-on advice. [4-6, 9, 20]

3. The Paediatric Society of New Zealand recommends that:

3.1 A child restraint is used on every trip for every child. Child passengers travelling in motorised vehicles should at all times be seated in a restraint that is correctly fitted into the vehicle, meets accepted Standards, and is suitable for the child’s age, height, weight and development. [3, 6, 7, 21]

3.2 Child Health Services and Well Child Service providers work with Certificated Child Restraint Technicians to ensure health professionals; families/whanau and caregivers receive expert technical advice and have access to information and products that promote and ensure the safe transport of children. [12]

3.3 The transfer and transportation of children by child health services should at all times be carried out in a manner consistent with best practice child restraint advice and families, whānau and caregivers are provided with every opportunity to access and use child restraints when travelling to and from hospital and/or child health services. [3, 6, 7, 21]

3.4 Families, whanau and caregivers of children with special health needs receive expert advice on the safe transportation of their child from Certificated Child Restraint Technicians who are working in collaboration with their Child Health Service Provider. This includes situations where the use of a usual child restraint is not achievable or may compromise the child’s health, for example, children with hip spicas, cardiopulmonary conditions and/or behavioural issues. [22]

3.5 Child restraints that are semi-reclining are used only for travel in the first months of life and travel time spent in a child restraint should be minimised. [23]

3.6 Child Health Services and Well Child Service providers routinely advise New Zealand families to:

   a. Seek advice from a Certificated Child Car Restraint Technician when purchasing and installing child car restraints. [12]
   b. Seat children rearward facing up until the age of two years, and then continue to seat them rearward facing for as long as practicable. [15]
   c. Ensure young infants are not left unattended to sleep in semi-reclining child restraints. [13, 14]
   d. Use head positioning inserts to ensure infants are correctly positioned and able to maintain a clear airway at all times they are in the child restraint. [13]
   e. Ensure children younger than the age of fourteen always travel seated in the back seat, for their safety. [3, 21]
   f. Ensure children are never placed in a restraint in the front seat of a vehicle where an airbag might be activated. This is critical with respect to rear-facing child restraints. [3]
   g. Only use lap belts when there is no safer alternative. [24]
   h. Continue to use a child restraint or booster seat until the child reaches 148 cm in height. [21]

References:


Carried (4 Abstained).
9. **PSNZ COMPLAINTS POLICY**
The draft complaints policy is a document that was prepared to address a recently received complaint.

It was moved

*That the Complaints Policy as circulated be accepted.*

Proposed Mollie Wilson  
Seconded Rosemary Marks  
Carried (2 Abstained)

10. **POSITION STATEMENT – NATIONAL AND REGIONAL CLINICAL NETWORKS FOR CHILD AND YOUTH SERVICES**
This document, circulated for the information of members, was put together after a number of people had been looking for the Society’s position statement and information on the clinical networks.

11. **NEW ZEALAND TELEPAEDIATRIC TRUST**
As advised earlier in the President’s report the Society has three nominated trustees on the Board of the New Zealand Telepaediatric Trust. The current PSNZ nominated trustees are Katherine Lissienko, Mollie Wilson and Rosemary Marks. Other Society members who are also trustees are Mike Sullivan (Deputy Chair), Karyn Bycroft, John Garrett and Roger Tuck. The network has continued to grow and the Ministry of Health have indicated that Vivid Solutions is their preferred supplier of telepaediatric services. Clinical consultation currently only applies to approximately 20% of the network usage and child health functions should take priority. However concerns were raised by some members about the patchy service. If the network is going to be used for distance clinical consultation members must be confident about the technical aspects. Concerns were raised regarding Vivid Solutions not adequately communicating and unresponsiveness. Rosemary Marks undertook to take these concerns back to the Trust and Vivid Solutions.

It was moved:

*That the PSNZ AGM*

(i) expresses concern as to the poor quality of service received from Vivid Solutions and seek a response

(ii) Recommends a monitoring framework –  
That Vivid Solutions send to the meeting convenor a feedback form after every meeting  
That feedback be reported quarterly to the Trustees and the Trustees report annually to the PSNZ AGM

Proposed Russell Wills  
Seconded Pam Jackson  
Carried unanimously.

12. **COUNCIL VACANCIES**
12.1 **President Elect** – Dr David Newman elected unopposed.  
12.2 **Nursing/Allied Health Upper North Island Rep**  
Nomination Received – Brenda Hughes

12.3 **Nursing/Allied Health Central North Island Rep**  
Nomination Received – Jenny Gibbs

12.4 **Nursing/Allied Health Lower South Island Rep**  
Nomination Received – Jean Simpson

12.4 **Medical Upper North Island Rep**  
Michael Shepherd Elected
12.5 **Medical Central North Island Rep**  
*Nomination to be forwarded*

12.6 **Medical Upper South Island Rep**  
*Nomination Received – Garth Smith*

12.7 **Medical Lower South Island Rep**  
*Nomination to be forwarded*

13. **SPECIAL INTEREST GROUPS AND COMMITTEES**

SIG reports were presented and can be viewed on the website. Dr Patrick Kelly who had chaired the Child Protection SIG since 2000 had tendered his resignation. The meeting acknowledged and thanked him for his tremendous work on behalf of children who have no voice.

14. **GENERAL BUSINESS**

14.1 **2012 Travelling Scholarships Awarded To:**

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<tr>
<th>Name</th>
<th>Position</th>
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<tr>
<td>Julie Chambers</td>
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<td>Thyna Orelly (Paediatrician, Vanuatu)</td>
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<td>Andrea Crawford</td>
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14.2 **ASM Planning**

The date and timing of the ASM needs to be considered. It is difficult to find a date that does not clash with other meetings. The meeting agreed the Scientific Committee might like to consider this and perhaps survey the membership.

14.3 **Report on APPA Meeting Sarawak, Malaysia**

Johan Morreau had represented the Society at the above meeting held in September 2012 and his report had been circulated for information.

There being no further business the meeting closed at 6.15 pm

The Chair thanked members for their attendance.