

Minutes

National Renal Transplant Leadership Team Meeting Operational Group

Date: Friday 3 April 2020

Time: 2.00 – 3.30 pm

Location: Zoom conference

Attendees:	Nick Cross (Chair)	Renal physician	CDHB
	Annette Pack	Portfolio Manager	MoH
	Carl Muthu	Transplant surgeon	ADHB
	Claire Beckett	Transplant coordinator	CCDHB
	Denise Beechey	Renal CNS	CMDHB
	Dilip Naik	Transplant surgeon	CCDHB
	Heather Dunckley	ASHI director	NZBS
	Janice Langlands	Donor coordinator	ODNZ
	Jo Burton	Kidney exchange coordinator	ADHB
	John Irvine	Renal physician	CDHB
	John Schollum	Renal physician	SDHB
	Justin Roake	Transplant surgeon	CDHB
	Karen Lovelock	Live donor coordinator	ADHB
	Kristin Wilson	Business manager LTU	ADHB
	Paul Manley	Renal physician – in lieu of Ian D	ADHB
	Philip Matheson	Renal physician	CCDHB
	Sue Townsend	Minutes	CDHB
Apologies:	Ian Dittmer	Renal physician	ADHB
	Jane Presto	Operations manager representative	CCDHB
	Ralph La salle	Team leader Planning & Funding	CDHB

Agenda item	Discussion
Standard agenda items	<ul style="list-style-type: none"> As this meeting was held under exceptional circumstances the standard agenda format was not followed.
Goal of meeting	<ul style="list-style-type: none"> Discussion of transplant pathways – how and when to close these, and once closed how to reopen. Current status confirmed:

Agenda item	Discussion
	<ul style="list-style-type: none"> • Auckland, Christchurch: Open for Deceased Donor kidney transplantation, Live donor transplantation deferred. • Wellington: Closed for all transplantation currently.
Basic Principles	<ul style="list-style-type: none"> • Nick identified two potential scenarios for the immediate future: <ul style="list-style-type: none"> ○ Things will remain as they are at present for some time with large social changes and planning disruption but only a small change in current clinical workload related to COVID 19 – this scenario has a degree of uncertainty. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> ○ There will be substantial service disruption which would stop clinical activities including transplantation. • Transplantation remains highly beneficial, deferring/stopping therefore creates risk for patients not transplanted (now and in future due to increasing waiting times). The transplant chain always operates in an environment of risk, COVID-19 situation is no different other than the degree of uncertainty around degrees of risk and future service disruption. • Patients on transplant medications may be at greater risk if exposed to COVID-19 although this is uncertain. • Unclear if risk is greater than remaining on dialysis, nor that transplant will increase risk of exposure, particularly where there are few cases as now. • Decision about whether to proceed with transplantation at any time is best made by the clinicians involved rather than NRTL or MOH. The role of this group is to advise DHBs to estimate risk relative to benefits and to advise to continue with transplantation as long as it is locally deemed appropriate to continue, if it is agreed it should continue. • Justin noted that the rate of community spread is currently low so there is no reason not to continue currently, although this should be reviewed when or if changes occur. • Risks are unknown, but information may come out from other countries regarding their transplant activities. • Justin's view of possible scenarios: <ul style="list-style-type: none"> ○ Spain/Italy situation where the healthcare system is broken and only emergency COVID-19 care is possible, with no transplants. This could potentially happen in New Zealand. ○ Health systems stand down elements of the transplant service to redirect resources to pandemic planning and mitigation, e.g. staff deployed to other areas, or if the risk profile is deemed to have changed. This means that transplantation would stop but not due to clinical need. • International experience with Rejection rates in New Zealand are low so high levels of immunosuppression in the early post-transplant phase are unlikely. • Philip commented that the next couple of weeks may be steady state and would give us a better idea of what is happening and may allow reopening in Wellington.
Deceased donor pathway	<ul style="list-style-type: none"> • Janice noted that there has been a reduction in number of referrals. The delay created by the requirement for a COVID-19 result before organs are retrieved may be preventing families from wanting to go ahead.

Agenda item	Discussion
	<ul style="list-style-type: none"> • ICUs don't have high occupancy levels currently, and ODNZ are still encouraging referrals. • There is also a reduction in availability of regional flights so sending donor bloods to Auckland for screening and tissue typing and moving kidneys around New Zealand will be a challenge. • General agreement from attendees that use of charter flights to deliver organs for transplantation would be entirely reasonable under the circumstances. • Principles of allocation should be preserved where at all possible, but ensuring that kidneys are used may override allocation. • Notification of possibly available organs will be as early as possible due to longer time required for logistics and planning. • An audit trail will be maintained of all transplants performed during the COVID-19 period. If a transplant is deferred for COVID-19 related reasons NRTS/ODNZ should be advised. <p>Decisions:</p> <ol style="list-style-type: none"> 1) Recommend continuation with deceased donor transplantation activity and allocation as per usual practice 2) Feedback and discussion to NRTLT of all instances of kidney transplantation occurring during the COVID-19 emergency
Live donor pathway	<ul style="list-style-type: none"> • There are currently no live donor transplants being performed in New Zealand. Christchurch has none scheduled currently, and Auckland has stopped due to implications for donors in the healthcare system, and also the fact that many are from outside the Auckland area. • Nick thinks current risk to live donors is very low – minimal risk of exposure within healthcare system. The issue for live donors is the combination of isolation and need for aftercare. • The principle to follow is that live donor transplants could proceed if not safely deferrable. Such situations are rare, e.g. the recipient is running out of dialysis access. Nevertheless these transplants are not infinitely deferrable as morbidity increases over time. • Once elective surgery is reinstated there will be access problems, so we need to be planning now for the step down from level 4. • Auckland particularly expect bulge of work from a prolonged deferral of procedures <p>Decision:</p> <ol style="list-style-type: none"> 1) Recommend limited continuation of live donor kidney transplantation where it cannot be safely deferred (noting risk accrues to recipient rather than donor) 2) Prepare strategy for advocacy for departments to use for theatre access for live donor transplantation when deferred surgery starts again (NRTS)
Assessments	<ul style="list-style-type: none"> • Are workups currently happening and can we continue to do them? If they are suspended a bottleneck will result.

Agenda item	Discussion
	<ul style="list-style-type: none"> • ADHB and CMDHB are not doing anything currently as assessments are classed as non-urgent. • Claire noted that CCDHB assessments have definitely slowed up as most non critical investigations have been cancelled by DHBs. This may change as we learn more about community risk over the next few weeks. • Coordinators should continue with as much assessment activity as possible to minimise the chance of being reallocated to other areas. • Community labs are offering reduced services at present, presumably to reduce population mobility. • NZ Blood is operating as usual but with staff working in shifts between 6.00 am and 11.00 pm. This means they have spare lab capacity so cross matching could be done at an earlier stage in the process. <p>Decision:</p> <ol style="list-style-type: none"> 1) Activity to continue to process donors and recipients within the current environment should continue where possible to prevent build-up of work and delay in completion of assessments
Nick's action points	<ul style="list-style-type: none"> • Review and update advice document in line with minutes • Develop guidance around restarting live donor transplantation • Ask individual units to advise referring centres about things they can do now as variations in protocol. • MoH guidance for DHBs will be issued and possibly posted to MoH website once signed off. Discussion today has been consistent with its content.
Meeting closed	<ul style="list-style-type: none"> • 3.15 pm
Next meeting	<ul style="list-style-type: none"> • Strategic group – Friday 29 May 2020 via Zoom • Action point: Please advise Nick if you would like to meet at any other time, including next week.