Minutes

National Renal Transplant Leadership Team Meeting

Strategic Group

Date: Friday 6 December 2019

Time: 9.45 am – 3.30 pm

Location: Kokako Room, Jet Park Hotel, Auckland

Present:	Nick Cross (Chair)	Renal physician	CDHB
	Carl Muthu	Transplant surgeon	ADHB
	Chanel Prestidge	Renal physician	ADHB
	Claire Beckett	Transplant coordinator	CCDHB
	Denise Beechey	Renal CNS	CMDHB
	Drew Henderson	Renal physician	WDHB
	Heather Dunckley	Clinical scientist	NZBS
	Ian Dittmer	Renal physician	ADHB
	Jane Potiki	Principal advisor	MoH
	Jane Presto	Operations manager representative	CCDHB
	Janice Langlands	Donor coordinator	ODNZ
	Jo Brown	Funding & development manager	ADHB/WDHB
	John Schollum	Renal physician	SDHB
	John Irvine	Renal physician	CDHB
	John Kearns	Consumer representative	Auckland
	Karen Lovelock	Transplant coordinator	ADHB
	Karen Macleod	Consumer representative	Dunedin
	Kristin Wilson	Business manager LTU	ADHB
	Philip Matheson	Renal physician	CCDHB
	Ralph La salle	Team leader Planning & Funding	CDHB
Guests:	Helen Pilmore	President elect (permanent guest)	TSANZ
	Theo Yiu	Advanced trainee	ADHB

Apologies: Andrew McNally, Dilip Naik, Justin Roake; Helen Pilmore for late arrival

Agenda item	Discussion
1. Meeting opened & introductions	Nick opened the meeting and introduced guests.
2. Conflict of interest	A reminder to submit a COI form if you have any conflicts of interest.
3. Minutes of previous NRTLT meetings	Strategic group meeting - 24/05/2019 Proposed John I / seconded Ian / approved Operational group meeting - 09/08/2019 Proposed John S / seconded Kristin / approved Teleconference meeting – 04/10/2019 To be held over until next operational group meeting
4. Change in leadership team	Stephen Munn has resigned from the leadership team. His place has been taken by transplant surgeon Carl Muthu from ADHB.

Agenda item	Discussion
5. Actions register	NZ Blood waiting list data to ANZDATA: The issue with privacy has been resolved but tissue typing data issue has not. Carry over to next meeting. Reports from VSEC Australia: No response has yet been received re a starting date. Nick has emailed VSEC and will follow up again early next year. Long term suspended: Patients suspended for more than 2 years are to be highlighted and reviewed by Ian in discussion with units. Overseas based donor complication: Following further discussion, NRTLT have made no representation to the MOH on this matter. General advice from Nick has not been sent out – rather, the issue was discussed at the NZ Nephrology meeting. Jane will check to see if there is an MoH FAQ and website update will include this accordingly. John I's proposed transplant probability scoring system: Hold over to next year.
5a. Correspondence	Nick to ADHB theatre staff thanking them for their work relating to the ANZKX surgery. Talk by Nick at ODNZ study day. Invited talk at Western Australia Transplant Service Perth re increasing live donation in NZ.
6. CD's report	Nick reviewed the history leading up to the establishment of NRTLT. New Zealand is performing well in comparison with other countries based on transplants per million population, and the total number of transplants in New Zealand is increasing. Highlights include good collaboration, involvement of patient representatives, provision of a better voice for coordinators, establishment of guidelines, innovations such as establishment of ANZKX and Hep C protocol. Frustrations include difficulty with performance metrics, and getting the message about donation out to the public. New donation (?and transplantation) authority. Unclear how NRTLT/NRTS will relate to this organisation, but opportunities exist to collaborate. Comments in discussion: The mapping project has made no impact on DHB provision of workup testing, with ongoing issues around cardiac testing for example. Further focus is a need on equity of access by ethnicity. **Actions:** Mapping project has insufficient visibility at the DHB level. **Jo** will discuss with Rachel Haggerty (chair of P&F Capital and Coast and chair of national GM P&F group). **Nick** will approach cardiac networks to discuss testing access, espica. Long term priorities: research re low transplant rates for Maori and Pacific, how can we reduce inequity. Jane commented that much of the solution to the inequity issue lies in prevention. Waikato are tracking patients by ethnicity from start of dialysis.

Agenda item	Discussion
7. QIM3/4 decision & recipient assessment time	Process impediments: The 11 processes being measured are not part of standard data collection by DHBs. Data collection thus far has been based on Excel spreadsheets which are far from foolproof. There has been a massive sunk cost to date in terms of coordinator and NRTS time, with not all units having supplied data, suspensions being excluded, and an estimated 5% error rate in data collected. Issues apply to both donor and recipient data. MoH analyst involvement: Jake Gallagher's work displays period of time to completion. Nick finds that the method of analysis is cumbersome and dependent on a high level of expertise, with information yielded of little practical value. Agreed that NRTS would halt further data collection and metric development as previously defined. Metrics remain key lever to improve access and equity for transplant. Transition metrics to include data already collected elsewhere. **Action: Nick to write to coordinators to thank them for their contribution.** **Action: Nick will develop paper for discussion around replacement metrics.**
8. Vessels with deceased donor kidneys	Vessels are taken and stored for 3 weeks for use for transplant or other patients. If the kidney goes to another centre should the vessels go with them? Carl states this would be extremely unlikely, so status quo to continue. **Action: Nick will email Dilip and Justin to determine if they have any comment – any issues to be passed on to Janice.**
9. Delay in DCD transplant proceeding	An allocated DC kidney was sent from Auckland to Wellington for a Nelson recipient. He had eaten a bite of a pie which caused a 1-2 hour delay. The transplant surgeon elected operate the following morning, resulting in a cold ischaemia time 26 hours which was not optimal for this kidney. The outcome has been satisfactory but the circumstances were not. As DCD numbers grow this could occur more often, and may negate any benefit from shorted cold ischaemic times achieved by allocating paired DCD kidneys to two different transplant centres. At present no change to the allocation rule is required, but this may need to happen in the future. **Action: Philip to report back to the DHB that the issue has been discussed, with no further action required.**
10. NKAS physician role in allocation and kidney acceptance decisions	A discussion of NKAS physician roles in NZ currently. This role has grown organically and has been provided by Auckland transplant nephrologists as part of their duties during oncall periods. "NKAS physician" is defined as the subset of Auckland Transplant Physicians undertaking NKAS roles, including: 1) Advice and liaison with ODNZ staff/ICU clinicians on potential donor suitability, including liaison with other physicians for advice where required (eg infectious diseases). 2) Discussion with other on call transplant physicians elsewhere in New Zealand if donor marginal for kidney donation, at NKAS

Agenda item	Discussion
	physician discretion. 3) Determination of deceased donor suitability for kidney donation, prior to retrieval 4) Determination of need for kidney biopsy (application of national guideline and at their/accepting physician discretion) 5) Review of DRMS algorithm and allocation, prior to offer (made by ODNZ) 6) Liaison with accepting transplant physician (where required) 7) Liaison with pathologist reporting kidney biopsies (where required). Generally agreed that physicians outside of Auckland could be involved in process to spread the load, broaden expertise and future proof service. Currently 4.5 physicians serve as NKAS physician (while on call). **Action: Ian/John to progress involvement of John on a trial basis.**
11. Tissue typing changes in Australia & TSANZ	**Tissue Typing changes** Helen reported concerns at TSANZ and Australia more generally about reducing availability of CDC cross match reagents and 'plates' which will severely limit/curtail availability of CDC cross matches in Australia within year or so. Transition to non-CDC methods (ie virtual cross match) involve multiple labs and multiple physicians due to practice pattern differences in Australia (eg acceptance of offers including interpretation of crossmatch results by oncall staff of differing knowledge and skillsets at multiple hospitals) will generate substantial education and harmonisation of approach requirements. Discussion that impact in NZ is likely to be much more limited because: 1) Plans already underway to replace CDC with virtual crossmatching 2) Much smaller volume of reagent and materials used means stocks likely to last longer 3) NZ's NKAS physician role ensures greater localised expertise and consistency, so any changes required are more readily achieved with much less need for a broad education approach. 4) Single laboratory means that there is no issue with interlab and methodological variability in MFI within NZ. **Action: Helen/Nick to feed back to TSANZ** **OrganMatch Committee** TSANZ request involved of somebody from NZ involved in the Organ Match committee, especially in light of ANZKX. Organ Match committee has been established to oversee that allocation software by TSANZ/OTA in Australia. The boundary between responsibility of that committee and RTAC is unclear. Discussion that NZ has two reps on RTAC subcommittee, RACOS, which currently overseas ANZKX (Nick has confirmed that with chair of RTAC and CD of ANZKX). This provides important clinical governance

Agenda item	Discussion
	over the combined ANZKX program. Merit of further NZ involvement unclear to NRTLT therefore. John I is happy to be involved, and supported by NRTLT, if necessary. **Action: Helen/Nick to advise TSANZ that NZ has two reps (Ian and John I) on RACOS, and to ask whether there would be any advantage to having a New Zealand member on the organ match committee.**
12. Backdating listing date for infants who need to grow prior to transplanting	Proposal from Starship Renal Service: For children under 10 kg in weight who are too small for transplantation but otherwise eligible for deceased donor waitlisting, the transplant listing date should be backdated to the dialysis start date when they grow to be large enough for transplantation. Currently, patients who are too small (but otherwise eligible and suitable) for kidney transplantation are placed on dialysis until they grow to >10kg prior to transplantation. Where they do not have a live donor, they may wait months or years until they reach the 10kg threshold before deceased donor listing. The date of listing is used for waiting time prioritisation, so time spent waiting to be large enough for transplant does not count towards waiting time. The number of patients in this category are very small, not more than one or two per year on average. There was discussion about the equity concerns of allowing backdating for this singular reason, compared to other temporary clinical barriers to transplantation. These were not compelling. The proposal was therefore agreed to. **Action: Chanel to advise all interested parties.** **Action: Nick to modify allocation and send to Chanel for checking.**
12. DDLC contracts after June 2020	Ongoing funding of DLCs beyond June 2020 will be discussed at MoH next week. If approval is reached MoH will write to DHBs to advise. NRTLT strongly supports continued funding and clarity for staff ASAP. **Action:** Jane will advise outcome of meeting
13. DDRMS error checking	Reports are being sent out and with a good response and a decrease in the error rate. This will continue to be done every month until the next NRTLT meeting, at which point it will be reviewed. **Action: Heather to send feedback and thanks to coordinators.**
14. Live donor cross match outcomes study	Study conducted and presented by Theo Yiu – advanced trainee ADHB. Discussion and support for uploading summary of talk (and other Advanced Trainee talks) to NRTS website. **Action: Theo will develop precis, Nick will ask for space on NRTS website for talks.**
15. AANZKX report	Programme commenced on 31 October 2019.

Agenda item	Discussion
16. Non directed donors in ANZKX and out kidney	This is to continue as per NZKX – exit kidney goes to transplant group where the chain started.
17. Social media & live donors	Discussion of patient-initiated use of social media to recruit donors. Broadly, NRTLT have concerns about some aspects of this practice including inaccurate information, risk of enhanced disparity of access (eg high health literacy patients are more likely to be successful at recruiting donors), resource implications for assessing teams, and privacy concerns. **Action: Nick to a draft of a one page guidance document for recipients / families considering use of social media outlining the risks and benefits.**
18. HCV positive deceased donor protocol	New Zealand has only a small number of HCV positive deceased donors. Being done successfully overseas with a high cure rate. Protocol doesn't require ethics or locality approval so is ready to go. Consenting will be done at the time of surgery. **Action: John S to make two amendments [add amendment to cover the short period between transplant and cure when the virus could potentially be transmissible; remove 'discarded' and replace with 'not transplanted'] then circulate to all solid transplant centres.** **Action: Jane Potiki to advise Andy Simpson that the protocol is going ahead.**
19. Allocation document amendments (including pre-emptive SPK listing)	Changes have been reviewed and are approved. **Action: Nick to send to Sue for uploading onto MoH website.**
20. Meeting schedule for 2020	See appendix below.
21. Meeting closed	2.30 pm

Appendix – meeting dates 2020		
Friday 31 January 2020	Operations	Teleconference
Friday 3 April 2020	Operations	Christchurch
Friday 29 May 2020	Strategic	Wellington
Friday 31 July 2020	Operations	Auckland
Friday 9 October 2020	Operations	Teleconference
Friday 4 December 2020	Strategic	Auckland
Friday 5 February 2021	Operations	Teleconference