

**Minutes**

**National Renal Transplant Leadership Team Meeting**

**Strategic Group**

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| **Date:** | Friday 29 May 2020 |
| **Time:** | 9.30 am – 12.00 noon |
| **Location:** | Zoom conference |
| **Attendees:** | Nick Cross (Chair) | Renal physician | CDHB |
|  | Andy McNally | Renal physician | HBDHB |
|  | Carl Muthu | Transplant surgeon | ADHB |
|  | Chanel Prestidge | Renal physician | ADHB |
|  | Claire Beckett | Transplant coordinator | CCDHB |
|  | Denise Beechey | Renal CNS | CMDHB |
|  | Dilip Naik | Transplant surgeon | CCDHB |
|  | Drew Henderson | Renal physician | WDHB |
|  | Heather Dunckley | ASHI director | NZBS |
|  | Ian Dittmer | Renal physician | ADHB |
|  | Jane Presto | Operations manager representative | CCDHB |
|  | Janice Langlands | Donor coordinator | ODNZ |
|  | John Irvine | Renal physician | CDHB |
|  | John Kearns | Consumer representative | Auckland |
|  | John Schollum | Renal physician | SDHB |
|  | Justin Roake | Transplant surgeon | CDHB |
|  | Karen Macleod | Consumer representative | Dunedin |
|  | Kristin Wilson | Business manager LTU | ADHB |
|  | Philip Matheson | Renal physician | CCDHB |
|  | Ralph La salle | Team leader Planning & Funding | CDHB |
|  | Sue Townsend | Administrator (minutes) | CDHB |
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| **Guests:** | Erica Fairbank | National education manager | Kidney Health NZ |
|  | Jo Burton | Kidney exchange coordinator | ANZKX |
|  | Kate Wyburn | Chair Renal Transplant Advisory Committee | Australia |
|  | Paul Manley | Transplant nephrologist | ADHB |
|  | Helen Pilmore | President elect | TSANZ |
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| **Apologies:** | Karen Lovelock | Live donor coordinator | ADHB |

| **Agenda item** | **Discussion** | **Action** |
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| 1. **Meeting opened & introductions**
 | * Nick opened the meeting and introduced guests.
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| 1. **Conflict of interest**
 | * A reminder to submit a COI form if you have any conflicts of interest.
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| 1. **Minutes of previous NRTLT meetings**
 | * **Strategic group meeting – 06/12/2019**Proposed Helen P / seconded Denise / approved
* **Operational group meeting – 31/01/2020 (teleconference)**Proposed Helen / seconded Kristen/ approved
* **Operational group meeting – 03/04/2020 (teleconference)**Proposed Phil / seconded Denise / approved
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| 1. **Actions review & correspondence**
 | **Actions review:****Hep C*** Protocol has been completed. No Hep c positive transplants have been carried out yet. Each centre is currently using its own protocol. MoH have been advised.

**Waiting list data from NZBS to ANZDATA*** Heather is continuing to progress this.

**VSEAC*** The preliminary report has been circulated to NRTLT clinicians. One point of note was the transfer of peanut allergy to a recipient.

**Backdating paeds listings*** This has been enacted (added to the allocation algorithm and uploaded to the MoH website).

**DDLC contracts after June 2020*** MoH are renegotiating with DHBs – contracts will be for a further 2 years.

**Registrar presentations*** Theo is working on an abstract of her presentation and Nick will request for these to be available on the MoH website. Registrars who have made prior presentations are welcome to also submit abstracts.

**Social media and live donors*** Nick will collaborate with Drew to develop a one page guidance document for recipients / families who are considering using social media to appeal for a kidney.

**Allocation document amendments****ACTION POINT: Nick will send to Sue for uploading onto MoH website.****Correspondence:****Letter to CCDHB re ANZKX*** No formal response has been received yet but Phil commented that there is positive feedback from staff including management about making the programme work well. Nothing has been sent to CDHB or ADHB but Nick is prepared to do so if the respective clinicians feel it would be beneficial.

**COVID-19 advice to units*** This became out of date immediately and has not been updated as the situation has changed rapidly.
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| 1. **NZ transplant activity 2019**
 | **Data review:*** Data for 2019 presented and discussed (refer to PowerPoint for this meeting).
* Feedback from last year’s review has been incorporated, including separation of LD/DD separation, more information on trends, and ethnicity breakdown.
* 2019 achieved a record for LD, DD and total transplants. There has been dramatic growth in DD and steady growth in LD transplants.
* iESKD is a new denominator for this year, with all new end stage patients nationally, by unit and by demographics. This is the number of incident treated end stage kidney disease patients from the calendar year prior.
* All groups are heading upwards but there remains a discrepancy by ethnicity .
* Units being able to see their own transplant numbers acts as a spur to increasing activity.

**ACTION POINT: Please send any further feedback about data or format of presentation to Nick.****Dissemination of report:*** The 2019 report is to go out by email to MoH, DHBs, ODNZ/NZBS, NRAB, Kidney Health NZ and TSANZ – approved by the meeting for sending.
* Drew noted that it is important for CDs to have a communication strategy for this information to be disseminated beyond their own level within their DHBs, ie to GMs Planning and Funding.
* Comment from John Irvine post the meeting – the report should also be circulated to urology and vascular surgeons and CDs of surgical units involved in transplant activity.
* Further impact could be gained by discussion at other DHB management forums eg TAS

**ACTION POINT: Nick and Jo will discuss and hope to present to TAS.** | **All****NC/JB** |
| 1. **Equity, transplantation & NRTLT/NRTS**
 | **How do we define the problem:*** What should NRTLT/NRTS (plus transplant centres, referring centres and the broader health system) do to progress the equity conversation?
* Achieving equity comes from an accumulation of small things, not one big thing. Everybody can contribute by being open to new ways, challenging preconceptions and seeking advice about different ways of looking at things.
* Ministry definition: ‘In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to getequitable health outcomes.’
* Rates of growth in transplantation are very similar across groups, but the gap remains. Pathways to transplant are complex with many points at which discrepancies can be generated. The MoH Health Equity Assessment Tool (HEAT, published in 2008) may be useful.
* Drew commented that equitable pathways should not be the goal, but equitable outcomes. ADHB has created care navigator roles to guide Maori patients through the pathway. Other DHBs are working on similar initiatives. However, once patients are on the waiting list inequity is not a factor.
* Unpublished Christchurch data on decisions made during transplant assessment show no differences on the basis of ethnicity or the length of time taken to get onto the waiting list. The only factors that did make a difference were obesity and lung disease. However, Maori appear to wait significantly longer once on the waiting list, even with suspensions removed. Possible factors underlying this not clearly identified.

**Where to from here:*** NRTLT terms of reference should be modified to reflect a focus on achieving equity. Need to report data by ethnicity so as to measure the effect of any changes.
* A research project is starting (ASSET WL, a collaboration between NRTLT members NC/JI/ID/HD/JK, others including Curtis Walker and Merryn Jones, and collaborators at Sydney University lead by Angela Webster) looking at waiting list patients and whether/how they progress to transplant.
* Drew, Jane Tamatia (endocrinologist) and Tania Huia are already doing work on equity. Waikato has a clinical lead for equity who is talking to services about pressure points for equity and will take issues forward systematically to P&F. Work is also being done in the Northern Region.

**ACTION POINT: Drew to discuss his work with Nick.****ACTION POINT: A subset of the leadership team will meet before next meeting to determine how best to engage with equity experts and how NRTLT should approach this as a body. This will include Jo, Denise, Drew, and anybody else interested. Subgroup to report back to the next operations meeting.** | **DH****JB, DB, DH, NC** |
| 1. **Access to cardiac screening texts**
 | * Nick has discussed with Gerry Devlin – Gerry is keen to assist and has agreed to review a draft proposal for a national approach.
* Cardiac testing is used prior to transplant to reduce the risk of poor outcomes – they largely work by excluding people from transplant.
* Interventional treatment for screen detected cardiac disease doesn’t appear to benefit asymptomatic patients undergoing other types of surgery or symptomatic patients with CKD when compared to medical treatment.
* The ongoing CARSK study is evaluating benefit/harm of screening waitlisted patients – recruitment still underway although this has been slowed by COVID-19.
* Downsides of cardiac testing: resource intensive, creates delays in waitlisting, and may be an inequity magnifier.
* In addition, support from cardiologists is variable with time, related to competing demands for scarce resources.
* Two possible solutions are to increase access to tests, which would be difficult or to reduce requirement for tests. Further data would be needed to support this latter option.

**ACTION POINT: Nick will start working on a policy to guide a reduction in cardiac screening, including comparing different DHBs protocols. Nick will report back on the feasibility of secured lists.** | **NC** |
| 1. **Replacement metrics**
 | * Deferred to next meeting
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| 1. **NKAS report**
 | * Stats presented – referred to PowerPoint.
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| 1. **NKAS longterm suspended patients**
 | * Deferred to next meeting
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| **10.5 Waiting list error checking** | * There are now very few errors needing correction, although there are still dialysis dates missing for some patients.
* Overall the checking process is working very well, with prompt responses from coordinators.
* Claire commented that it is easier to work from this report than the previous one.
* Once a month is agreed on as an appropriate frequency.
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| 1. **ANZKX report**
 | * Jo Burton presented data on performance of ANZKX since it went live in August 2019.
* COVID-19 has had an impact, with the third match run which was planned for February 2020 being put on hold.
* Australia stopped transplantations mid to late March, followed by New Zealand shortly thereafter, so the programme was suspended and matched pairs returned to the waiting list.
* Current status: 34 pairs enrolled and 5 nondirected donors ready.
* There are now 9 transplants to organise across 3 New Zealand centres, and dates have been scheduled.
* New processes causing some unease, so measures are in place to increase communication about expectations and processes involved in ANZKX, including discussion at RACOS.
* New Zealand transplant list is slightly reduced compared to last year, with not much change to waiting list time by months.
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| 1. **TSANZ issues**
 | * Due to COVID-19 the annual general meeting was cancelled and the President’s Prize deferred. Weekly TLRG meetings initially focused on stopping transplantation in Australia but are now discussing restarting transplantation.
* Australia are planning on starting virtual X match
* Clinical guidelines on donor assessment for risk of malignancy transmission – this is close to publication.
* Review of consenting process and associated education programmes underway – this will ensure that potential recipients are fully informed about the implications of higher risks kidneys.
* TSANZ aiming to increase engagement with New Zealand – currently has only 30 New Zealand members. Increased membership sought particularly among younger members and trainees.
* Election for a New Zealander coming up – Nick will remain involved until then.
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| 1. **Immunisation advice update**
 | * The role of NRTLT/NRAB is to provide clinical advice specific to transplantation. IMAC provides advice about vaccine science and availability.
* Three items in the current document need to be rectified – hep B vaccine is not available in stronger strength (only 20 mcg). Recommendation of a second booster dose of flu vaccine - to be removed as not supported.
* Meningococcal vaccine – most is group b but this is currently not funded, so a recommendation to be inserted that patients purchase this.

**ACTION POINT: Please advise Nick if you would like to review the immunisation document.** | **All** |
| 1. **Meeting schedule**
 | * The meeting scheduled for July in Auckland will be held by Zoom.
* Aim to hold the December meeting as face to face in Auckland.

**ACTION POINT: Sue to notify the venue of cancellation.** | **ST** |
| 1. **Other business**
 | **LKDA book printing:*** Kristin is currently dealing with MoH and printer – we are looking at moving from A5 to A4 as this is cheaper to print.

**DHB policy re funding live donor travel from overseas:*** Denise and Ralph advise there are no issues at their DHBs.

**Supplemental antibody testing:*** The kit supplier is now manufacturing kits for other antibodies. Melbourne has requested that New Zealand patients in ANZKX be tested with these supplemental kits. There is proven utility, but the issue will be cost. Melbourne would charge for the kit only, the price would be $180 per test, and each patient may need two tests. The charge would come to NZBS initially and then be invoiced on to the relevant DHB. In the future NZBS is planning to validate the kits for use in the NZ Tissue Typing lab.
* Agreement this was appropriate.
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| **Meeting closed** | * 12.05 pm
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| **Next meeting** | * **Operations Group – Friday 31 July 2020 via Zoom**
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