COPE Kick-off Meeting Minutes
Milestone Report

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Version	Date	Comments
1.0	15/01/2013	First draft - KC
1.1	04/02/2013	Additions - ZA
1.2	05/02/2013	Review - RP

Contents

Executive Summary:

The kick-off meeting was milestone 48 (MS48 of the FP7 project 305934 COPE) and this document summarises the events which took place at the meeting, the results achieved and finally the actions decided for the coming months. This work was carried out as part of WP10 COPE Management. The meeting took place on the 10th and 11th of January in University College, the University of Oxford. The work package leaders presented the initial plans for the delivery of their work packages and invited questions and concerned from those members of the clinical or the experimental work packages. There was a detailed and productive exchange of concerns and ideas, and work-plans were adjusted and actions recorded.

Material from slide presentations has not been duplicated here. Confidential material has been redacted.

Summary of main discussion points:
WP1: Change in operational schedule to accommodate differing procedures in participating centres. Trial is now concerning hypothermic ECMO vs. normothermic ECMO in place of immediate cooling.

WP2: discussion of general protocols, recruitment rate plus consent, no major changes suggested.

WP3: Discussion of possible changes to the donor-pool resulting in no change, plus the outcome measures: survival vs. longer term prospects using markers. Discussion on-going.

WP4: An in depth discussion of the logistics and feasibility of the whole work package as coordinated through P07. No concrete solution reached but WP participants are to make discussion and resolution of the logistics a priority in the coming months.

WP5&6: Discussion about Hemo2life supply, plus RBC vs. hemo2life in liver normothermic preservation, postponed until meetings can take place with P12.

WP7: ZA reiterated the necessity of WP7 sample use agreements being considered in all clinical trial protocols.

WP8: CET discussed randomisation procedures, and plan to distribute a protocol checklist to Clinical WP leaders.

Summary of Actions:

WP#	Inst#	Personnel	Action
EC	P01	KC, RP	Contact the other four transplantation FP7's to facilitate synergy.
EC	P01	KC, RP	Regularly update CK with dissemination of results
WP1	P08	MB	Distribute/report on updated organ discard rates in the region from most recent data.
WP1	P08	MB	Send ZA and CET DGF data for cold ECMO to determine trial group numbers, and determine if the group size needs to be changed.
WP1	P08	MB	Distribute updated trial protocol to the consortium.
WP1	P01a	all	CET to determine randomisation procedure and inform trial leaders.

WP2	P01	PF, all	PF and trial team to decide on which pro-inflammatory markers we wish to use.
WP2	P01	PF, all	PF and trial tem to set biopsy dates
WP2	P03	AP, AG	AP to approach German ethics committee about second round phone consent.
WP2	P03	AP	AP to check University insurance.
WP2	P03	AP	Include retrieval checklist for Essen retrievals
WP2	P01	PF	PF to finalise protocol for WP
WP2	P01	PF	Protocol to state solution choice left to local preference.
WP2	P01, P01a	PF, CET	PF/CET to establish recruitment rate for each centre.
WP2	P01	PF, Oxford	PF to recruit trial coordinator ASAP.
WP3	P03	AP	Alter protocol to include minimum perfusion time of 2 hours
WP3	P01a	all	CET to do establish the role of GFR in predicting long term graft survival and feed back to AP and the clinical group .
WP3	P03	AP	Protocol to state that COPE patients to be excluded from any other Trials.
WP4	P07	IJ	IJ to look into the on-going UK continuous vs. delayed perfusion study
WP4	P07	IJ	Clinical group agree that a Belgian and Dutch combined initiative is the best solution – IJ to update logistics.
WP4	P07	JP	JP to approach Belgian centres re. logistics.
WP4	P07, P02	JP, HL, IJ, CM	JP and IJ to explore logistics further – with Netherlands.
WP4	P07, P02, P10	JP, IJ, HL, CM, AVDP	WP4 participants to discuss science and logistics problems in a conference call very soon to iron out any problems, and confirm alterations to the proposed study.
WP4	P07	JP, IJ	IJ and JP to provide data on machine perfusion on DCD organs to build sample size.
WP4	P07	JP	JP to look into data on machine perfusions effect of DGF at 1 year on SCD, ECD and DCD
WP4	P07, P02, P01	IJ, CM, PF	IJ CM and PF to look into the evolution of DCD age form Belgium and UK, specifically the proportion of DCD donors over 60 in the last 10 years.
WP4	P07, P02, P10, P01	All	WP4 participants agree to revisit this is the near future with more data.
WP4	P01	PF, RP	PF and RP to explore age and DCD in the UK
WP7	P01	ZA, RP	WP1-4 consent must include sample use agreements for WP7 and the biobank.
WP7	P01	ZA, RP	RP/ZA to distribute WP7 and biobank protocols and SOP's to partners for comment /additions.
WP8	P01a	PM, JOC, LP	CET to distribute checklist to trial leaders.
WP8	P01a	PM	PM to discuss central randomisation with Surgical Trials Unit and report back.
WP8	P01a	PM	PM and statistical support to discuss design and trial management with WP members involved.
WP9	ALL	All	Partners to send dissemination ideas and news to KC and RP.
WP10	P01	KC	Disseminate logo shortlist and disseminate ASAP
WP10	P01	KC	Update website copy to make it more public-friendly
WP10	P01	KC	Add a patient contact page to website

WP10	P01	KC	KC to weight the pre-financing towards the SME's OrganOx and Organ Assist
WP10	P01, P02	KC, HL	KC and Groningen to invoice partners for pre-application costs.

Meeting Details

10th-11th January 2013
University College, Swire Conference Rooms, Oxford

Attendees:

Consortium Members

Douglas Rees	Aqix Ltd (SME)
Thomas Minor	University of Bonn
Peter Morris	Centre for Evidence in Transplantation
Liset Pengel	Centre for Evidence in Transplantation
John O'Callaghan	Centre for Evidence in Transplantation
Andreas Paul	University of Duisburg-Essen
Anja Gallinat	University of Duisburg-Essen
Henri Leuvenink	Universitaire Medisch Centrum Groningen
Cyril Moers	Universitaire Medisch Centrum Groningen
Jacques Pirenne	University of Leuven
Ina Jochmans	University of Leuven
Maria Bringas	Servicio Madrileno de Salud
Melchior van Voorden	Organ Assist Products B.V. (SME)
Arjan van der Plaats	Organ Assist Products B.V. (SME)
Les Russell (10/01/13)	OrganOx (SME)
Colin Storey (11/01/13)	OrganOx (SME)
Raphael Thuiller	Universite de Poitiers
Rutger Ploeg	University of Oxford
Zeeshan Akhtar	University of Oxford
Katherine Corr	University of Oxford
Maria Kaisar	University of Oxford
Peter Friend	University of Oxford

Guests:

Charles Kessler	European Commission
Linda Pialek	University of Oxford

Agenda:

12.00	Arrival Tea and Coffees	
12.30	Prof Rutger Ploeg	Welcome to Partners
12.45	Dr Charles Kessler, EU Project Officer	EU Expectations, and COPE SWOT Analysis

13.15	Katherine Corr, Project Administrator	Communication, Website & Logo.
13.45	Q & A	
14.00	Tea and Coffee Break	
14.30 – 17.30	**Clinical WP Discussion:** WP leaders to present draft proposal and lead discussions on each clinical work package. Goal is to finalise scientific and operational protocols in detail and identify hurdles and propose solutions, plus expand on the role SME's per work package	WP leaders to present draft proposal and lead discussions on each experimental work package to finalise experimental and detailed design / outcomes, identify hurdles and propose solutions.
19.00	Drinks reception and Welcome Dinner in University College dining room plus Consortium Photo	

Friday 11th January 2013

08.30	Linda Pialek	Contracts, Finance and Reporting
09.00	Dr. Maria Bringas	WP1 Presentation plus Q & A
09.30	Prof. Peter Friend	WP2 Presentation plus Q & A
10.00	Prof. Andreas Paul	WP3 Presentation plus Q & A
10.30	Prof. Jacques Pirenne	WP4 Presentation plus Q & A
11.00	Tea and Coffee Break	
11.30	Prof. Thomas Minor	WP5 Presentation plus Q & A
12.00	Prof. Henri Leuvenink	WP6 Presentation plus Q & A
12.30	Dr. Zeeshan Akhtar	WP7 Presentation plus Q & A
13.00	Farewell to Partners	
13.10	Farewell Lunch & Consortium photo	

Minutes:

Thursday 10th January 2013

Rutger Ploeg (RP) welcomed partners to the COPE Kick-off meeting, and described the format of the two half-days: Day 1 with Charles Kessler (CK) and Katherine Corr (KC) presenting the EC expectations and a SWOT analysis and the COPE communication systems respectively; followed by a short break and then the group splitting into 2 parts to tackle the refinement of the clinical ad experimental work packages. Day 2 starting with Linda Pialek (LP) presenting the contractual and financial requirements, followed by the WP leaders presenting their adjusted WP plans to the whole Consortium Council.

CK presented a short presentation on EC expectations, before moving into more specific areas relevant to COPE and a project SWOT analysis.

Questions & Discussion:
CK suggested the possibility of a networking event between COPE and other FP7 [HEALTH.2012.1.4-1], awarded projects relevant to transplantation.

CK also suggested regular progress communication with himself.

CK and RP discussed the possibility of adding partners to the Consortium as the project continues. CK confirmed it would be possible to add partners to the Consortium but that this would require a contract amendment.

JP inquired as to the degree of flexibility concerning Annex 1. CK confirmed that it was possible to make amendments but this would also require a contract amendment.

ACTION: KC and RP to contact the four transplantation FP7's to facilitate synergy.
ACTION: KC to include CK in dissemination of results

KC presented the working COPE logo, plus the COPE working website, and a demonstration of the Sharepoint site.

Questions and Discussion:
RT suggested removing the tag-line from the logo to make it softer and add in the project's longer title; following which the Consortium discussed the logo. KC and RP suggested work continues on the logo and a shortlist to be circulated shortly.

ZA and RT suggested the website be accessible to lay persons. RT also suggests adding in a section through which interested patients can get in touch with the trial leaders.

Regarding the Sharepoint site the Consortium questioned whether the site would replace e-mail as a form of communication. KC confirmed that Share-point facilitates communication, but the real utility is the ability to work collaboratively on documents, without the document being duplicated and confused in a multi person email chain. JP questioned the safety of the site in terms of patient data sharing. KC confirmed that the site is secure, and if greater security is required you can create documents/folders that can only be accessed by certain members of the Consortium.
CM asked if the Sharepoint site is compatible with Macintosh computers, KC confirmed it is.

ACTION: KC to draw up logo shortlist and disseminate by the 25th January

ACTION: KC to update website copy to make it more public-friendly
ACTION: KC to add a patient contact page.

Clinical WP Discussion:

The Clinical work group met on the afternoon of the 10th January, chaired by Rutger Ploeg. The group included: Maria Bringas (MB), Peter Friend (PF), Anja Gallinat (AG), Ina Jochmans (IJ), Maria Kaisar (MK), Charles Kessler (CK), Cyril Moers (CM), Peter Morris (PM), John O'Callaghan (JOC), Andreas Paul (AP), Liset Pengel (LP), Jacques Pirenne (JP), Les Russell (LR), and Melchior van Voorden (MV). Minutes by Katherine Corr (KC).

WP1 Questions and Discussion
MB presents WP1 on behalf of Jose Nunez and Madrid.

PM asked for the definition of advanced CPR from the trial inclusion/exclusion checklist, to which the answer is "hospital based CPR" including intubation. MB also clarified that the 120minutes should be read as 120 minutes from the point of cardiac arrest.

The Consortium discussed organ discard rates following a question from JOC and questioned the high discard rate in Madrid. MB agrees to distribute up to date donor/discard rate information.

MB discussed the problem with randomisation in the trial, and that one centre does not perform the double-balloon procedure. The outline plan had proposed a randomised controlled trial comparing double-balloon placement versus normothermic extracorporeal membrane oxygenation (ECMO). MB suggested that all three trial centres all alter the trail protocol to perform the same procedure: normothermic ECMO vs. hypothermic ECMO. The group discussed this and concluded that normothermic versus hypothermic ECMO is still a very relevant question.

ZA asked about available figures on DGF differences between double-balloon and hypothermic ECMO, PM confirmed CET would need to receive the DGF rates in order to calculate the group numbers for the trial.

CM asked if there are any issues regarding randomisation with the surgical team i.e. surgical teams going off protocol with AP highlighting that if the livers are being retrieved this could cause a problem. MB confirmed that the transplant co-ordinators are typically notified early if there were any prospect that the liver will be used for transplantation, which is seldom the case, and liver utilisation will be determined prior to randomisation.

The consortium agreed that it is important that the trial protocol is identical across the three trial sites, and since the only procedures that can be performed across the three sites is hypothermic ECMO, the Consortium agreed to a trial of hypothermic ECMO vs Normothermic ECMO.

MB asked CET about proposed randomisation systems, whether they will be envelopes or a more centralised phone or web based system. RP requested that randomisation be central and electronically administered, rather than by envelopes.

MB also asked about mechanisms for patient consent. ZA and RP confirmed that this needs to be written into the protocols for each trial by the trial leader, who will set up the entire system for all participants including ethical consent, protocols, recruitment and consent.

ACTION: MB to distribute/report on updated organ discard rates in the region from most recent data.
ACTION: MB to send ZA and CET DGF data for cold ECMO to determine trial group numbers, and determine if the group size needs to be changed.
ACTION: MB to distribute updated trial protocol to the consortium.
ACTION: CET to determine randomisation procedure and inform trial leaders.

WP2 Questions and Discussion:
PF presented the initial WP trial protocols for WP2 as they stand for the Clinical group.

PF reiterated the question about randomisation, and whether it will be phone/web based.

RP questioned whether the local surgeons will be instructed in the trial protocol to use UW or HTK as the flush medium. PF is of the opinion that this would be up to individual surgeon's preference/local practice.

RP questioned the machine settings for the re-perfusion sequences, and if they can be altered either by design or by accident. PF and OrganOx confirmed that the machine is tamper-proof, and can be 'on' or 'off'.

PF questioned the group about the protocol for biopsies. AP suggested just post implantation (7 days), just after reperfusion and then at either 3 or 6 months.

PF asked CK about the point in CK's presentation about dissemination being a project long activity and not only for month 54. CK replied that results, activity and significant movement in the WP's should be disseminated as they happen throughout the project.

The clinical group discussed patient recruitment, with PF stating that their recipients are consented whilst they are on the transplant waiting list as then patients are easy to identify.

AP highlighted that the recruitment rates in Essen may change owed to alterations in the ET policy on organ allocation. PF and AP to liaise regarding the recruitment rates from Essen.

AP asked PF about the liver machine protocol, and duration of the normothermic liver machine perfusion. PF suggested this would be left to the individual transplant centres and not stipulated by the protocols.

RP stated that participating centres should not delay engraftment of the liver allografts that have been machine perfused.

The Clinical group discussed the high recruitment rate of 10/month, and agree that although ambitious this target is achievable.

IJ asked PF about randomisation and when this occurs, and PF confirmed that this will happen whilst the recipient is on the transplant waiting list. Reconfirmation of consent can be sought verbally on the telephone in some centres. Donor consent will be sought in some centres, but the legal requirement to do this remains unclear. PF elaborated that in the UK we will operate through 2-3 retrieval teams who will be appropriately trained.

AP stated that in Germany pre consent of the recipient can be obtained but this will need to be - affirmed in writing. PF suggested approaching the ethics committee about the possibility of changing the second round of consent to phone based. AP agreed.

JOC asked for the distribution of machines and is informed that 2 will reside in the UK with the retrieval teams, and one each in the other trial countries.

AP stated that indemnity insurance is expensive. RP stated that a trial run by the University of Oxford is covered under the Universities umbrella indemnity policy, and urged AP to check into institutional policies in his University.

RP confirmed that Organ Ox will be undertaking the training for the retrieval teams on how to use the device, but that it is vital that the samples taken come back to the bio-bank. AP noted that getting the team there with the machine and someone qualified (surgeon and technician) to prime the device. PF stated that there is funding in place to train someone in how to use the device and obtain the necessary samples.

PF noted that the important issues to develop a retrieval checklist in Germany are: radius of travel (will the team get there in time) whether the organ has been allocated to Essen, has consent been collected, can the team get to the organ in time?

AP noted that there are 150 people on the organ list in Essen – it will take time (3-6 months to get pre-consent from them all, but PF noted that it took time to get consent in the UK too, that someone in the clinic was tasked with collecting consent.

RP asked for 6 month timeline. PF stated that the trial coordinator will be appointed, and the protocol agreed and ethics approval obtained in this time. PF expected the first patient to be recruited in month 8. RP suggested that PF work on protocol prior to appointing the coordinator and get them finalised ASAP

ACTION: PF and trial team still to decide on which pro-inflammatory markers we wish to use.
ACTION: PF and trial tem to set biopsy dates
ACTION: AP to approach German ethics committee about second round phone consent.
ACTION: AP to check University insurance.
ACTION: AP to include retrieval checklist for Essen retrievals
ACTION: PF to finalise protocol for WP

WP3 Questions and Discussion:
AP presents the initial work package plan for WP3

PF questioned the sole enrolment of ECDs and whether the trial should be extended to DCDs also. RP highlighted that the greatest benefit of the machine perfusion was observed in ECDs and therefore it was likely end storage machine perfusion would have the greatest effect on this cohort of donors.

RP asked the clinical group if they were in agreement on the minimum 2 hours mandated by the trial protocol as it stands. The group agreed but discuss the possible issues arising from transplant teams keeping the organ on perfusion for longer than necessary. AP agreed this would be worth auditing.

PF suggested that it may be difficult to record a long-term outcome in the two years we have available to us; and suggests we use surrogate markers to indicate long-term outcome. PM considered there are no reliable surrogate markers to indicate long-term outcome. The group discussed the merits of recording long-term prospects using markers vs. survival. PF stated that studies have already demonstrated survival rate, but what would be interesting is showing the increased longevity of a transplanted organ. RP suggested the CET look into the feasibility of GFR and its relation to improving graft survival and feed back to the clinical group

ACTION: Group decide to that a minimum perfusion period of 2 hours is correct.
ACTION: CET to do establish the role of GFR in predicting long term graft survival and feed back to AP and the clinical group .

WP4 Questions and Discussion:
IJ presented the preliminary workplan for WP4 on behalf of Jacques Pirenne and Leuven.

IJ introduced the study presenting the caveat that she and JP wanted to confirm the question proposed was still relevant and were concerned about the logistics of the study.

IJ argued that the study was asking the same question as the previous European machine perfusion trial with the addition of oxygen. JP wondered if it might be more valuable to combine WP 3 and 4 and make it one trial but using both ECD's and DCD's. PF argued that the trials were more valuable if performed separately, with one asking about timing (WP3) and the other asking about oxygen (WP4).

IJ mentioned that there is a study currently in the UK looking at continuous vs. delayed perfusion. IJ to look into this in more detail, as this could be important as two similar past studies showed different results.

RP argued that the previous studies had shown that DGF was reduced with machine perfusion, and that WP4 is a necessary next step to evaluate whether we can improve results by the addition of oxygen. An important argument is also that since the MP trial the typical DCD donor has aged. Centres accept now DCD kidneys from 60-75 year old donors. This will affect not only DGF but also graft failure as we know from the ECD.

PF focused the discussion on the issue of logistics and asks whether it is feasible for the trial still to be done. IJ stated that in the Netherlands it can be undertaken with no problems. However there are worries that for the Belgian leg there is not enough budget to fund the student team, which in any case can be a problem in Belgium with the centres involved.

HL asked if the chances of success logistically might be improved if the trial were coordinated by the Netherlands, with Belgium simply "taking part", with the Dutch contingent having dedicated people to work in Belgium? JP stated that this could help, but that Dutch students in Belgian centres might be problem. HL stated that the teams would only be putting the organs on machines, and not undertaking any surgical procedures, all it would take is a team of well trained professionals. JP stated that the Netherlands undertaking the training for a common team might help.

RP suggested inviting the lead surgeons in the transplant centres to help, that they will appreciate a study trying to provide good quality transplants. RP also noted that the Consortium is in agreement that the question remains a valid one especially since ECD donors are growing older, but the logistics need work. He suggested that JP liaise with the Beligum centres to see what is workable.

ACTION: IJ to look into the on-going UK continuous vs. delayed perfusion study
ACTION: Clinical group agree that a Belgian and Dutch combined initiative is the best solution – IJ to update logistics.
ACTION: JP to approach Belgian centres re. logistics.
ACTION: JP and IJ to explore logistics further – with Netherlands.
ACTION: PF and RP to explore age and DCD in the UK

Experimental WP Discussion:

The experimental group met the afternoon of the 10th, it was lead by Henri Leuvenink and included Maria Kaisar (MK), Thomas Minor (TM), Arjan van der Plaats (AVDP), Douglas Rees (DR) and Raphael Thuillier (RT). Minutes by Raphael Thuillier.

HL and Thomas Minor presents the experimental packages.

Questions and Discussion:
After a quick round of presentations, MK who was joining the group for the first time presented her work on proteomics analysis of clinical samples. This was met with great interest by the group, and a discussion about the inclusion of animal samples in MK's collection took place. It was agreed that this concept showed promises. The discussion about the specifics of samples/timing will take place at a later time.

More discussion regarding the liver WP followed, this time regarding colloids. The choice of colloid was then discussed. Three colloids, at different doses and molecular weight, can be tested: Hydroxyethylstarch (HES), Polyethylene glycol (PEG) and Dextrans. HES, used in KPS (recommended solution for machine perfusion), has shown several problems regarding blood clotting and damage to kidneys, and his thus not preferred by the group. The choice would then be between Dextrans and PEGs.

RT shared the experience of his lab regarding PEGs, a molecule with which they have had very good results in static preservation, and pointed out that its use in machine preservation needed careful experimentation since it could be deleterious at the wrong dose/molecular weight. However, its high level of performance in the IGL1 solution during machine perfusion tests in a pig model of transplantation warranted the testing of PEGs for Aqix.

The remaining points of the experimental plan (please see presentation) were rapidly discussed as all parties agreed on the need for such tests

ACTION: Consult with Clinical group in the session on Friday 11th.

Friday 11th January 2013

Linda Pialek (LP) presented her talk on EC Contracts, Finance and Reporting.

Questions and Discussion:
RP asked LP about the SME's and their machines WRT the pre-financing and that they will need a much higher level of pre financing than 38%. LP and CK confirmed that within the first pre-financing payment the coordinator can distribute the funds however they choose. The consortium agree that the pre-financing should be weighted to the SME's to allow for the construction of the devices.

RP asked about the use of the indirect costs, that each partner can use it however they like. LP replied that as we have chosen 'flat rate' we do not need to account for indirect costs, and each partner institution can choose how to apply these indirect costs.

HL asked about the timesheets and the fact that scientists often have irregular and overlong working weeks in terms of hours. LP confirmed that the timesheets should reflect the proportion of contracted weekly working hours you are spending on the project.

LP introduced the online reporting tool and informed the consortium that all reporting on COPE will be done online. Each partner will do their finance report (Form C) online and a financial justification (for which you can partly use evidence from timesheets, but the coordinator alone will fill in the science reporting sections.

RP asked about adding partners. CK stated that the consortium can add a partner at any time via amendment, but the science work-plans will have to be altered to demonstrate their contribution, and the budget re-apportioned to cover them. RP asks about partners who are offering services at no cost to the project. CK stated that then they can be added with a '0' budget, but that partners cannot financially subcontract each other, therefore any new industry partner cannot pay another partner for work they are contributing to.

RP and HL spoke to the consortium regarding the costs borne by the partners in pre-application. KC states that this cannot come off of the project funds. All partners agree to cover their proportional share of the costs involved in application.

ACTION: KC to weight the pre-financing towards the SME's OrganOx and Organ Assist
ACTION: KC and Groningen to invoice partners for their shares of the pre-application costs.

WP1
MB presented the proposed clinical trial in WP1 which has changed to a trial of hypothermic ECMO (regional machine perfusion) against normothermic ECMO. MB had been in contact with Spanish colleagues: Madrid, Grenada and Alicante have agreed to the concept of the comparison.

Questions and Discussion:
HL confirmed that the DGF rates using hypothermic ECMO were comparable to double balloon and therefore numbers of patients required for the new study would be similar. MB to provide details of the DGF rates observed in the trial centres with hypothermic ECMO.

WP2
PF presented the amended package work-plan and mentioned the actions and alterations from Thursday's session, including waiting to hear from Essen about the second consent affirmation to be conducted by phone, plus the randomisation procedure.

Questions and Discussion:
RP asked if it might be an option to ease the back table by stapling the diaphragm rather than over-sewing. PF answered that stapling will require several staples, and it will be easier and cheaper to simply stitch.

The consortium discussed the solution to be used, AP confirmed that for Essen the local preference is HDK solution, but PF reported that he was not sure what it was in Oxford, but that it might be different. PF stated that the choice should be left to the surgeon in charge to limit the number of stipulations in the protocol.

PF highlighted that the number/types of molecular markers to be evaluated had not been finalised and would be the subject of further discussions with the Consortium

PF asked JP if he was happy with performing MRCP at 6 months. JP Confirmed.

Participants in the work package agree to establish likely recruitment rate for each of the centres for the consortium's information.

PF noted that he will process the recruitment of the Trial Coordinator/DPhil student as soon as possible to get somebody in place ASAP, to meet the various trial milestone deadline dates.

PF is questioned on histology envisioned, and replied that he envisions seven to be performed over the course of the trial for each participant, but that they may require more. The situation will be monitored.

ACTION: Solution choice left to local preference.
ACTION: WP2 to establish recruitment rate for each centre.
ACTION: PF to recruit trial coordinator ASAP.

WP3
Andreas Paul presented the updated work plan for Work Package 3.

Questions and Discussion:
AP is questioned as to the decision to exclude those patients who die in the first seven days. It is discussed whether they should be included as they should not alter results, as those patients should be evenly distributed throughout the project.

HL discussed the primary and secondary outcome measures, before clarifying the use of immunosuppressive agents in the study. AP stated that centres should continue to use their current immunosuppressive regimes and these constitute best clinical practice.

JP asked about involving patients in more than one clinical trial. It was agreed that patients will be enrolled into only one clinical trial - as is policy in most academic institutions.

ACTION: Patients to be excluded from any other Trials.

WP4
IJ presented WP4 and opened up the discussion from the previous day on the relevance of the science, and the logistical problems to the Experimental group.

Questions and Discussion:
RP stated that all of these questions have been discussed year earlier when putting the grant application together.

The issues highlighted in the previous session were discussed with the Consortium including outcome measures, the validity of the scientific question and issues surrounding logistics.

IJ argued that using DCD's was of low importance scientifically as they are the smallest group of available organs worldwide, and asks if it would make more sense to apply the science to ECD organs as they are the most similar to living organs. RP argued however that given the year on year increase in the number of DCD donors world-wide the biggest benefit is likely to be observed in DCD donors; specifically older DCD donors. TM stated that DCD's are most likely to benefit from oxygen, so the trial should use them, and that it was not a good idea to move to ECD. He also stated that only minor experiments had been conducted on DCD models in Germany.

RP stated that the question of machine perfusion vs. machine perfusion plus oxygen on DCD's would yield the most impressive and useful results. IJ to obtain data on eGFR from the previous MP trial for CET to aid in the estimation of sample size.

AP questioned the recruitment rate in Belgium and the number of "drop-outs". IJ stated in the previous MP trial the "drop-out" rate was significant until support with retrieval was obtained with ORS.

IJ stated that this still leaves the logistical problem. JP stated that sending machines out with student teams can be difficult, and that there is no centralised retrieval team that can be trained. JP asks if the oxygen can be added at the end which will make it logistically simpler. RP suggested that given the results of the previous MP trial if a benefit is to be observed it will be most likely observed with continuous rather than just pre-implantation MP and therefore the former of these would be the best study.

JP agrees to look into machine perfusions effect of DGF at 1 year on SCD, ECD and DCD; and IJ (with CM) plus PF to look into the evolution of DCD age form Belgium and UK respectively. PF reiterates that they should also look at the proportion of DCD donors over 60 in the last 10 years. RP states the cohorts should be 50-55, 55-60, 60-65 etc.

WP4 participants agree to revisit this is the near future with more data.

ACTION: WP4 participants to discuss science and logistics problems in a conference call very soon to iron out any problems, and confirm alterations to the proposed study.
ACTION: IJ and JP to provide data on machine perfusion on DCD organs to build sample size.
ACTION: JP to look into data on machine perfusions effect of DGF at 1 year on SCD, ECD and DCD
ACTION: IJ CM and PF to look into the evolution of DCD age form Belgium and UK, specifically the proportion of DCD donors over 60 in the last 10 years.
ACTION: WP4 participants agree to revisit this is the near future with more data.

WP7
ZA presents WP7 and the bio-bank setup to consortium on behalf of Oxford.

Questions and Discussion:
MB is asked how the restructured WP1 will effect the sampling. MB stated this the new way is better as it allows for continuous sampling.

IJ asks how stand-alone the metra is and PF replied that it was completely separate except for glucose which requires manual sampling. PF stated that they had not discussed the frequency of

sampling yet, but it will be no more than every 4 hours. ZA asks about oxygen monitoring, and PF confirmed that this data is logged automatically.

It is agreed that RP, ZA and MK will sit down with WP leaders and find out their requirements/preferences for sample collection, and include this in trial and W7 protocols.

IJ also agrees to discuss with ZA later a similar bio-banking exercise which happens as a matter of course in Belgian hospitals.

RP reiterates the usefulness of WP7 and the biobank, in that the consortium can work out DGF rates, and identify and validate the findings of the study.

PF asks about the COPE samples interaction with RP's other intiative 'QUOD'. ZA states that it is a similar procedure and will utilise the same SOP's.

It is discussed that consent on any of the trials will have to include agreement for consort involvement with collected materials.

MK confirms to the group that there will be plenty of perfusate remaining after the COPE testing to provide material for analysis in the future when new techniques may be available.

RP/ZA agrees to send all SOP's to everyone involved in trials and experimental work for comments and additions. All protocols for WP7 are done at the same time as they are used throughout the work packages.

ACTION: WP1-4 consent must include sample use agreements for WP7 and the biobank.
ACTION: RP/ZA to distribute WP7 and biobank protocols and SOP's to partners for comment /additions.

WP5 & 6
HL presents the Experimental introduction to the consortium.

Questions and Discussion:

TM presents the workplan for WP5, and the discussion that took place the day before.

PF asked for clarification on the sample sizes for the various time periods. TM confirms a mis-type on the presentation and alters it.

HF presents the workplan for WP6, and the discussion and decisions that took place the day before.

HL confirms that the ECMO will be in vivo.

WP8
PM briefly speaks to the consortium about CET's role in WP8, and lets the WP leaders that he will be sending around a checklist shortly for what should be built into their trial protocols.

PM also reports on CET's upcoming statistical support from the surgical trials unit in Oxford via Doug Altman, and the value this adds to the project. PM plans to meet with Dr. Altman in two weeks (from

11/01/2013) to discuss aspects of the COPE project, including the central randomisation procedure, and will report back discussing trial design and management with WP leaders.

ACTION: CET to distribute checklist to trial leaders.
ACTION: PM to discuss central randomisation with Surgical Trials Unit and report back.
ACTION: PM and statistical support to discuss design and trial management with WP members involved.

WP9
RP spoke to the group briefly about dissemination and confirms the following methods of continuous dissemination through the life of the project:

- COPE Website and news feed
  ESOT dedicated pages for the information of other interested transplanters
- Bottom up communication
- Selective results dissemination
- Updates via burst emails
- Updates via societies in constituency
- ESOT Meetings in 2013 and 2015 with a COPE workshop
- European Donation Congress 2014 with a COPE dedicated workshop
- Plus the usual events: abstracts, publications, presentations posters etc.

RP invited partners to get in touch if they have any ideas for further dissemination

HL suggests the TTS meeting in San Francisco, a possible special issue about machine preservation from the COPE project, and a dedicated workshop.

ACTION: Partners to send dissemination ideas and news to KC and RP.

RP finally thanked all partners and especially CK for attending such a productive meeting. RP went on to state that in the next few weeks the trial protocols should be in place, and the work can begin. He also reminded the partners to get in touch with KC if they have any operational questions.

Meeting adjourned.