NHS ENGLAND SPECIALISED SERVICES

CLINICAL PANEL REPORT

Date:	17 April 2019. Agenda item 6.7
Intervention:	Extracorporeal membrane oxygenation (ECMO)
Indication:	Bridge to lung transplant
ID:	1803
Gateway:	Policy Gateway 2 (Round 3)
Programme:	Internal Medicine
CRG:	Specialised Respiratory

Information provided to the panel

Policy proposition

Evidence review produced by Public Health England in September 2018

CPAG Summary Report

Clinical Panel report (October 2018) (Round 1)

Clinical Panel report (December 2018) (Round 2)

Response from NHS Blood & Transplant following Round 1

Notes from the ECMO Extraordinary meeting held January 2019

Additional report for Clinical Panel

Key elements discussed

The panel has discussed the bridge to transplant issue before. The intervention is reasonable for the individual patient. The panel's concern remain whether prioritising patients acutely ill for a lung transplant deprives others who may have an equal place in access to lung transplant.

The panel wanted to hear how the prioritisation of patients was undertaken by NHS-BT to identify whether the priority given to the acutely ill is consistent. A working group was established between NHS England and NHS-BT to explore the issues.

Patients included are only those who were already on the transplant waiting list and then acutely deteriorated. In this situation these patients are added to a 'superurgent waiting list for a lung'. The patients tend to be younger with cystic fibrosis. So the argument was that the younger patients would have a longer period of benefit.

The evidence from NHS-BT is that there is a different case mix in this patient group. As the superurgent list is recent (2 years) there is not an evidence base that they have better outcome than the wider cohort waiting transplant.

The population health approach is that the number of organs available is limited. Those with rapid deterioration will take an organ that may have been available to someone else on the transplant waiting list. The early outcome of transplant tends to be worse from those receiving an organ from ECMO. The length of stay following transplant was significantly worse for those on ECMO compared to the comparator group (mechanical ventilation).

Clinicians identify the younger patients as 'more deserving' to lung transplant. The policy redistributes organs to the younger patients at a greater cost to the NHS (ITU ECMO support), and at slightly worse acute outcomes and uncertain longer term improved outcome.

If there is a need to prioritise the younger patients then the Panel were concerned that these patients had not been already identified as a higher priority on the transplant waiting list.

It was raised whether there was a further inequity that there are other patients who suddenly deteriorate who were no already on the transplant waiting list. It was identfied that, probably, it is too complex to add a suddenly deteriorating patient to the transplant wait list.

The access to the superurgent waiting list for liver transplant was discussed.

There was a vote taken of panel members (yes 5, no 4) to decide on the proposal next steps. Members were divided in their view.

Recommendation

The policy should progress to stakeholder testing and consultation as a 'routine commissioning' position. At both steps the proposal should be accompanied by the key questions of individual access vs population equity.

Why the panel made these recommendations

Clinical commissioners have to consider whether the rule of rescue is being applied (see example paper on the subject http://discovery.ucl.ac.uk/1358337/1/Orr_Wolff_Reconciling.pdf). There is a dilemma between the decision where to place an investment for additional healthcare expenditure for the benefit of the population against the moral dilemma of managing the care of an individual where an intervention may prevent death. The mortality on the lung transplant waiting list is high (more than 20%), ECMO is a high cost treatment. It is clear that introducing this policy will not increase the numbers of organs available to transplant. The Clinical Panel (by design) mixes experts in population health with individuals working in clinical care, the decision to proceed was marginal. It recommends that a full debate is held by CPAG considering the conflicting stances of such a policy.

Documentation amendments required

There should be a document produced to accompany the policy to CPAG which outlines the benefit to the population versus the benefit to the individual.

Declarations of Interest of Panel Members: Judith Smith declared a personal conflict

Panel Chair: James Palmer, Medical Director