SPECIALISED COMMISSIONING - CLINICAL EVIDENCE EVALUATION CRITERIA FOR A CLINICAL COMMISSIONING POLICY PROPOSITION THAT IS NOT PROGRESSING

URN: 1803
TITLE: Extracorporeal membrane oxygenation (ECMO) as a bridge to lung transplant (all ages)

CRG: Specialised Respiratory
NPOC: Internal Medicine
Date: 12/12/18

The panel were presented a policy proposition for routine commissioning.

Advice	Conclusion of the panel
The Panel should provide advice on matters relating to the evidence base and policy development and prioritisation. Advice may cover: • Uncertainty in the evidence base • Challenges in the clinical interpretation and applicability of policy in clinical practice • Challenges in ensuring policy is applied appropriately • Issues with regard to value for money • Likely changes in the pathway of care and therapeutic advances that may result in the need for policy review.	The Panel noted that further details had been provided in response to the request arising following consideration of this policy at a previous Clinical Panel. NHS Blood & Transplant (NHS BT) were thanked for this response. Panel noted that: • There is evidence that ECMO is effective with the outcomes for those patients going on to receive transplants almost as good as for patients receiving transplants not on ECMO. • NHS BT has created a 'super urgent list' with only patients on ECMO eligible. NHS BT advise that most patients on the super urgent list receive a transplant, with a median wait of 7 days. • NHS BT advise that ECMO is most likely to be used in two patient groups: patients with pulmonary fibrosis and patients with cystic fibrosis. 'This could distribute donor lungs away from the other large patient group, patients with chronic obstructive pulmonary disease. The latter group has the best survival on the waiting list and patients are often transplanted to improve quality of life rather than prognosis. It could therefore be argued that such redistribution is appropriate.' • NHS BT states that commissioning of ECMO is unlikely to result in an increase in donor lung utilisation or in the number of lung transplants. Clinical Panel were concerned that the use of ECMO could: increase the total cost of the

	transplant pathway, reduce the overall benefit (as patients receiving a transplant when on ECMO fare slightly less well than those receiving a transplant not on ECMO) and not increase the total number of successful transplants taking place. Panel wanted to understand how patients on the transplant waiting list were currently prioritised. Was it possible to identify patients at greatest risk of rapid deterioration and prioritise them for transplant? Panel noted the comment that some patients were awaiting a transplant for 'to improve quality of life rather than prognosis'. How were these patients prioritised? Panel noted that 25% of patients die whilst awaiting transplant and wanted to understand whether further work on prioritisation could reduce this figure. Linked to this, Panel were concerned that implementation of the policy would lead to a change in the case mix of patients receiving transplants. Organs used for patients on the 'super urgent' list would not be available for patients not on the super urgent list. These patients may then be at risk of death or becoming too unwell for a transplant. The Panel requested that further work was carried out to understand the potential impact of the proposition before development continues. As such, a working group should be formed with representation including 3-4 members of Clinical Panel, representation from NHS Blood & Transplant (including the NHS Blood & Transplant Medical Director if possible) and representation from clinician with experience of transplanting lungs. Specific consideration should be given to: • A more detailed description of the patient pathway. • Whether further technical work including modelling would help inform the decision and understand which patient groups would tend to benefit and which patients would tend to have a disbenefit from the introduction of ECMO. This is needed to properly inform the equality impact assessment.

	• What risk stratification and prioritisation already takes place for patients added to the transplant waiting list? • What opportunity is there to prioritise patients on the waiting list to minimise the numbers progressing to rapid deterioration and death. • Would it be appropriate to change the priority for patients on the waiting list where the benefit is to achieve quality of life benefit rather than life extension benefit? • Could the production of an algorithm aid understanding of the priority order for transplant. • The proposition is 'all ages', but Panel wanted to understand whether ECMO is appropriate clinical practice for children. Panel noted that in order to inform relative prioritisation from a commissioner perspective the potential impact of introducing ECMO on the population of patients awaiting transplant would need to be clearly understood. Panel noted that ECMO may already be provided to some patients as a bridge to transplant. However, ECMO is not routinely commissioned for this clinical indication. The proposition should return to Panel at a later date after this work is complete.

Report approved by:
David Black

Clinical Panel Co-Chair

21/12/18

Post meeting note

A working group, chaired by the Clinical Panel Co-Chair, was formed, to consider the questions the Clinical Panel had asked to be addressed and informed on. The main issue considered was the net overall value and benefit to the population of the policy proposition and whether the total number of transplants will increase. The working group reviewed the relevant organ allocation and patient selection policies.

The Working Group agreed a narrative report to submit to the Clinical Panel along with the data analysis addressing the specific questions and issues raised including details about the allocation schemes and governance. Notes from the Working Group meeting were also submitted to Clinical Panel for information.