NICE Update Bulletin March 2015 for guidance issued Wednesday 25th March 2015

Hyperlinks to the relevant NICE web page are included, to activate link left click on your mouse. Details are also available from the NICE website (**http://www.nice.org.uk**)

Type	Guidance title and reference number
Technology Appraisals (TAs)	**Pomalidomide for relapsed and refractory multiple myeloma previously treated with lenalidomide and bortezomib (TA338)** **Background** Multiple myeloma is a type of cancer that affects cells in the bone marrow. Symptoms can include bone pain, bone fractures, anaemia, loss of appetite, excessive bleeding after cuts or scrapes, and frequent infections. **Recommendations** 1.1 Pomalidomide, in combination with dexamethasone, is **not recommended** within its marketing authorisation for treating relapsed and refractory multiple myeloma in adults who have had at least 2 previous treatments, including lenalidomide and bortezomib, and whose disease has progressed on the last therapy. 1.2 People whose treatment with pomalidomide was started within the NHS before this guidance was published should be able to continue treatment until they and their NHS clinician consider it appropriate to stop. **The technology** Pomalidomide is an oral immunomodulatory drug analogue of thalidomide that directly inhibits myeloma growth. Pomalidomide in combination with dexamethasone has a UK marketing authorisation for the 'treatment of adult patients with relapsed and refractory multiple myeloma who have received at least 2 prior treatment regimens, including both lenalidomide and bortezomib, and have demonstrated disease progression on the last therapy'. **Rifaximin for preventing episodes of overt hepatic encephalopathy (TA337)** **Background** Hepatic encephalopathy is a brain disorder that is associated with liver disease. Sometimes, when a person's liver stops working properly, toxins can build up in the bloodstream. These toxins may cause the brain to malfunction (known as encephalopathy), leading to changes in personality and behaviour, and muscle problems. **Recommendations** 1.1 Rifaximin is recommended, within its marketing authorisation, as an option for reducing the recurrence of episodes of overt hepatic encephalopathy in people aged 18 years or older. **The technology** Rifaximin is a semi-synthetic derivative of the antibiotic rifamycin. Rifaximin decreases intestinal production and absorption of ammonia, which is thought to be responsible for the neurocognitive symptoms of hepatic encephalopathy, thereby delaying the recurrence of acute episodes. Rifaximin has a marketing authorisation in the UK 'for the reduction in recurrence of episodes of overt hepatic encephalopathy in patients aged 18 years or older'. **Empagliflozin in combination therapy for treating type 2 diabetes (TA336)** **Background** In diabetes the amount of glucose (sugar) in the blood is too high, which can lead to

serious health problems. Insulin is a hormone made by the body to control the level of sugar in the blood. Type 2 diabetes occurs when the body cannot make enough insulin, or when it cannot use the insulin it produces properly.

Recommendations

1.1 Empagliflozin in a dual therapy regimen in combination with metformin is recommended as an option for treating type 2 diabetes, only if:

- a sulfonylurea is contraindicated or not tolerated, or
- the person is at significant risk of hypeglycaemia or its consequences

1.2 Empagliflozin in a triple therapy regimen is recommended as an option for treating type 2 diabetes in combination with:

- Metformin and a sulfonylurea, or
- Metformin and a thiazolidinedione.

1.3 Empagliflozin in combination with insulin with or without other antidiabetic drugs is recommended as an option for treating type 2 diabetes.

1.4 People currently receiving treatment initiated within the NHS with empagliflozin that is not recommended for them by NICE in this guidance should be able to continue treatment until they and their NHS clinician consider it appropriate to stop.

The technology

Empagliflozin is an orally administered selective sodium-glucose cotransporter-2 (SGLT-2) inhibitor, which lowers blood glucose in people with type 2 diabetes by blocking the reabsorption of glucose in the kidneys and promoting excretion of excess glucose in the urine.

Financial factors

The guidance is not expected to have a significant impact on NHS resources. Empagliflozin provides an additional treatment option for people with type 2 diabetes alongside other treatment options which have similar costs and outcomes.

Rivaroxaban for preventing adverse outcomes after acute management of acute coronary syndrome (TA335)

Background

Acute coronary syndrome is the term used for a group of heart problems which includes unstable angina and heart attacks. These are heart problems that cause chest pain or discomfort. The pain is caused by a blockage or narrowing of one of the main blood vessels in the heart (coronary arteries). After an acute coronary syndrome, people may have raised levels of cardiac biomarkers in their blood. Cardiac biomarkers are proteins that are released into the blood when heart muscle has been damaged. People who have had an acute coronary syndrome are at risk of having further problems, such as a heart attack or stroke, caused by blood clots.

Recommendations

1.1 Rivaroxaban is recommended as an option within its marketing authorisation, in combination with aspirin plus clopidogrel or aspirin alone, for preventing atherothrombotic events in people who have had an acute coronary syndrome with elevated cardiac biomarkers.

1.2 Clinicians should carefully assess the person's risk of bleeding before treatment with rivaroxaban is started. The decision to start treatment should be made after an informed discussion between the clinician and the patient about the benefits and risks of rivaroxaban in combination with aspirin plus clopidogrel or with aspirin alone, compared with aspirin plus clopidogrel or aspirin alone.

1.3 A decision on continuation of treatment should be taken no later than 12 months after starting treatment. Clinicians should regularly reassess the relative benefits and

	risks of continuing treatment with rivaroxaban and discuss them with the patient. **The technology** Rivaroxaban, co-administered with aspirin alone or with aspirin plus clopidogrel or ticlopidine, is indicated for the prevention of atherothrombotic events in adult patients after an acute coronary syndrome with elevated cardiac biomarkers. The licenced dose is 2.5 mg twice daily. Patients should also take a daily dose of 75–100 mg aspirin or a daily dose of 75–100 mg aspirin in addition to either a daily dose of 75 mg clopidogrel or a standard daily dose of ticlopidine. Ticlopidine is not listed in the British National Formulary (BNF).
Highly specialized technology guidance (HSTs)	**None published so far this month**

Note: From January 2015 NICE has decided to use a single set of methods and processes to develop all NICE guidelines, whether they are clinical, public health, social care, safe staffing or medicines practice.

Technology appraisals, interventional procedures, medical technologies and diagnostics guidance; and quality standards and advice products, are unaffected by this change.

NICE Guidelines (NGs)	**Maintaining a healthy weight and preventing excess weight gain among adults and children (NG7)** **Background information** This guideline makes recommendations on behaviours that may help people maintain a healthy weight or prevent excess weight gain. These recommendations support those made in other NICE guidelines about effective interventions and activities to prevent people becoming overweight or obese. This includes interventions and activities in which weight is not the primary outcome, such as those aimed at preventing cardiovascular disease or type 2 diabetes, improving mental wellbeing or increasing active travel. Excess weight may increase the risk of coronary heart disease, hypertension, liver disease, osteoarthritis, stroke, type 2 diabetes, and some cancers such as breast, colon, endometrial and kidney cancer. People who are overweight or obese may also experience mental health problems, stigmatisation and discrimination because of their weight. **The recommendations in full cover:** 1 Encourage people to make changes in line with existing advice 2 Encourage physical activity habits to avoid low energy expenditure 3 Encourage dietary habits that reduce the risk of excess energy intake 4 Further advice for parents and carers of children and young people 5 Encourage adults to limit the amount of alcohol they drink 6 Encourage self-monitoring 7 Clearly communicate the benefits of maintaining a healthy weight 8 Clearly communicate the benefits of gradual improvements to physical activity and dietary habits 9 Tailor messages for specific groups 10 Ensure activities are integrated with the local strategic approach to obesity

Financial factors

This guideline is not expected to have a significant resource impact. The recommendations in the guideline are intended to support other NICE guidelines on effective interventions and activities that prevent people becoming overweight or obese. Preventing a small increase in weight gain at a population level may avoid significant future costs. Implementing this guideline will support or improve the achievement of savings identified in previous guidelines.

Excess winter deaths and morbidity and the health risks associated with cold homes (NG6)

Background information

This guideline makes recommendations on how to reduce the risk of death and ill health associated with living in a cold home. The aim is to help meet a range of public health and other goals. These include:

- Reducing preventable excess winter death rates.
- Improving health and wellbeing among vulnerable groups.
- Reducing pressure on health and social care services.
- Reducing 'fuel poverty' and the risk of fuel debt or being disconnected from gas and electricity supplies (including self-disconnection).
- Improving the energy efficiency of homes.

The recommendations in full cover:

1 Develop a strategy

2 Ensure there is a single-point-of-contact health and housing referral service for people living in cold homes

3 Provide tailored solutions via the single- point-of-contact health and housing referral service for people living in cold homes

4 Identify people at risk of ill health from living in a cold home

5 Make every contact count by assessing the heating needs of people who use primary health and home care services

6 Non-health and social care workers who visit people at home should assess their heating needs

7 Discharge vulnerable people from health or social care settings to a warm home

8 Train health and social care practitioners to help people whose homes may be too cold

9 Train housing professionals and faith and voluntary sector workers to help people whose homes may be too cold for their health and wellbeing

10 Train heating engineers, meter installers and those providing building insulation to help vulnerable people at home

11 Raise awareness among practitioners and the public about how to keep warm at home

12 Ensure buildings meet ventilation and other building and trading standards

Financial factors

Organisations are advised to assess the local resource implications of this guideline. Potential additional costs may be incurred as follows:

- Resources for a single-point-of-contact health and housing referral service
- Providing tailored solutions to improve the energy efficiency of homes (for example, insulation, boilers and gas central heating). Costing statement: Excess winter deaths and illness (March 2015) 9 of 10
- Training for health and social care practitioners, housing professionals and

faith and voluntary sector workers.

- Training for heating engineers and meter installers (funded by the private sector)
- Ensuring buildings meet ventilation and other building and trading standards.

Potential areas for savings locally are:

- Reduced GP consultations, out-of-hours calls, attendances at walk-in centres, district nurse visits and drug prescriptions.
- Reduced emergency department visits.
- Reduced inpatient admissions.
- Reduced social care service costs.

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (NG5)

Background information

This guideline offers best practice advice on the care of all people who are using medicines and also those who are receiving suboptimal benefit from medicines. It updates and replaces recommendation 1.4.2 in the NICE guideline on medicines adherence. It also replaces PSG001 Technical patient safety solutions for medicines reconciliation on admission of adults to hospital.

The recommendations in full cover:

1.1 Systems for identifying, reporting and learning from medicines‑related patient safety incidents

1.2 Medicines-related communication systems when patients move from one care setting to another

1.3 Medicines reconciliation

1.4 Medication review

1.5 Self-management plans

1.6 Patient decision aids used in consultations involving medicines

1.7 Clinical decision support

1.8 Medicines-related models of organisational and cross-sector working

Financial factors

This guidance has the potential to be cost saving. There is variation in clinical practice across the country therefore NICE encourages organisations to evaluate their own practices against the recommendations in the NICE guideline and assess the resource impact locally.

Depression in children and young people: Identification and management in primary, community and secondary care (CG28 update)

Background information

This updated guideline covers the identification and treatment of depression in children (5–11 years) and young people (12–18 years) in primary, community and secondary care. Depression is a broad diagnosis that can include different symptoms in different people. However, depressed mood or loss of pleasure in most activities, are key signs of depression. Depressive symptoms are frequently accompanied by symptoms of anxiety, but may also occur on their own.

Recommendations on psychological therapies and antidepressants have been added to and updated.

The recommendations cover

1.1 Care of all children and young people with depression

	1.2 Stepped care 1.3 Step 1: Detection, risk profiling and referral 1.4 Step 2: Recognition 1.5 Step 3: Mild depression 1.6 Steps 4 and 5: Moderate to severe depression 1.7 Transfer to adult services **Financial factors** New recommendations have been added on psychological therapies and antidepressants. The resource impact of implementing the new recommendations will depend on current clinical practice. If implementing the recommendations increases the number of fluoxetine prescriptions, there will be a cost for commissioners.
Interventional Procedures Guidance (IPGs)	**Implantation of a duodenal–jejunal bypass liner for managing type 2 diabetes (IPG518)** **Recommendations** 1.1 Current evidence on the safety and efficacy of implantation of a duodenal–jejunal bypass liner for managing type 2 diabetes is limited in quality and quantity. Therefore the procedure should only be used **in the context of research**. 1.2 Further research should give details of patient selection, including information about use of the procedure in patients with different levels of BMI. The research should provide information on complications; reasons for early removal of the device; medication used for treating type 2 diabetes, both when the device is in place and after its removal; and control of type 2 diabetes after device removal. NICE may update the guidance on publication of further evidence. **The procedure** Endoscopic implantation of a duodenal–jejunal bypass liner (DJBL) is a procedure that aims to improve glycaemic control in people with obesity or who are overweight. The procedure is done with the patient under general anaesthesia or sedation, using image guidance. The liner is positioned endoscopically (via the mouth). Using a delivery catheter, a capsule containing a single-use impermeable DJBL is positioned in the duodenal bulb just distal to the pylorus. It is secured there using an integral spring metal anchor. The liner is advanced distally into the jejunum using a tension wire that is part of the 'introducer' device. It extends about 60 cm down the small intestine and forms a barrier between food and the intestinal wall, delaying the mixing of digestive enzymes with food. **Insertion of endobronchial nitinol coils to improve lung function in emphysema (IPG517)** **Recommendations** 1.1 Current evidence on the safety and efficacy of the insertion of endobronchial nitinol coils to improve lung function in emphysema is limited in quantity and quality. Therefore the procedure should only be used **in the context of research**. 1.2 Research studies would preferably include observational data collection and should describe patient selection in detail. Outcome measures should include lung function, dyspnoea score, exercise tolerance, quality of life and long-term safety. Studies should also report on the influence of the procedure on subsequent lung surgery. NICE may update the guidance on publication of further evidence. **The procedure** Insertion of endobronchial nitinol coils is intended to be a minimally invasive alternative to lung volume reduction surgery. The procedure reduces the volume of diseased areas of the lungs. This minimises airflow to the least functional diseased lung segments, allowing air to flow to healthier parts of the lungs, with the aim of improving gas exchange and, as a result, lung function. The procedure is intended to improve

lung function in patients with upper or lower lobe heterogeneous emphysema, as well as in patients with multiple emphysematous lobes with focal tissue defects.

Implantation of a left ventricular assist device for destination therapy in people ineligible for heart transplantation (IPG516)

Recommendations

1.1 Current evidence on the efficacy and safety of the implantation of a left ventricular assist device for destination therapy in people ineligible for heart transplantation is adequate to support the use of this procedure provided that **normal arrangements** are in place for clinical governance, consent and audit. For people who are eligible for heart transplantation, refer to NICE's interventional procedure guidance on short-term circulatory support with left ventricular assist devices as a bridge to cardiac transplantation or recovery.

1.2 Patient selection should be done by a multidisciplinary team that includes a cardiologist with a specialist interest in heart failure, a cardiothoracic surgeon and a cardiac anaesthetist.

1.3 Implantation of left ventricular assist devices for destination therapy should be done by surgeons, anaesthetists and intensive care specialists with special training and regular practice in performing this procedure and caring for these patients. Subsequent care should be provided by a multidisciplinary team including staff with the expertise to deal with patients' medical and psychological management, and with the maintenance of their left ventricular assist devices.

1.4 Clinicians should enter details on all patients who have a left ventricular assist device for destination therapy onto the UK Central Cardiac Audit Database.

The procedure

'Destination therapy' is a term that refers to the implantation of a left ventricular assist device (LVAD) with the aim of providing permanent circulatory support to people with advanced heart failure who are ineligible for heart transplantation. The LVAD is implanted with the patient under general anaesthesia and involves open heart surgery, usually with cardiopulmonary bypass. Initially, the pump component of the LVAD is placed in the pericardium. An inflow pipe is then inserted into the left side of the heart (usually the left ventricle) and an outflow pipe is inserted into the systemic arterial system (usually the aorta). Subsequently, a power cable, attached to the pump, is brought out of the abdominal wall to the outside of the body and attached to a control system and battery. Once the pump begins to work and support the heart, the cardiopulmonary bypass machine is removed and the chest incision is closed. The LVAD draws oxygenated blood from the failing left ventricle and pumps it into the systemic arterial system under pressure.

Insertion of a balloon device to disimpact an engaged fetal head before an emergency caesarean section (IPG515)

Recommendations

1.1 Current evidence on the efficacy and safety of inserting a balloon device to disimpact an engaged fetal head before an emergency caesarean section is inadequate in quantity and quality. Therefore, this procedure should only be used with **special arrangements** for clinical governance and audit or research.

1.2 Clinicians wishing to insert a balloon device to disimpact an engaged fetal head before an emergency caesarean section should take the following actions:

- Inform the clinical governance leads in advance that they intend to perform the procedure when necessary
- Audit and review clinical outcomes of all women treated by the insertion of a balloon device to disimpact an engaged fetal head before an emergency caesarean section

1.3 Further research and data collection should report the impact of performing the procedure on the time taken from the decision to perform a caesarean section to delivery of the baby. Technical failures, including the need for repositioning of the device and for subsequent manual disimpaction of the fetal head; and any

complications resulting from use of the procedure should be recorded. Fetal outcomes should also be reported. NICE may update the guidance on publication of further evidence.

The procedure

Insertion of a balloon device to disimpact an engaged fetal head aims to elevate the fetal head, without trauma, immediately before an emergency caesarean section, usually at full dilatation.

Transanal total mesorectal excision of the rectum (IPG514)

Recommendations

1.1 Current evidence on the safety and efficacy of transanal total mesorectal excision (TaTME) to remove the rectum is limited in both quantity and quality. Therefore, this procedure should only be used with **special arrangements** for clinical governance, consent and audit or research.

1.2 Clinicians wishing to undertake TaTME should take the following actions:

- Inform the clinical governance leads in their NHS trusts
- Ensure that patients understand the uncertainty about the procedure's safety and efficacy and provide them with clear written information. In addition, the use of NICE's information for the public is recommended.

1.3 TaTME should only be done by surgeons who are experienced in laparoscopic and transanal rectal resection and who have had specific training in this procedure.

1.4 Clinicians should enter details about all patients undergoing TaTME (for malignancy or a benign indication) onto the TaTME registry and review local clinical outcomes.

1.5 NICE encourages further research into TaTME of the rectum. Patient selection should be explicitly documented. If the procedure is used to treat malignancy, outcomes should include completeness of excision, recurrence rates, survival, quality of life outcomes and avoidance of the need for a stoma in the long term. All complications should be reported, specifically including incontinence.

The procedure

Transanal total mesorectal excision (TaTME) aims to improve the clinical outcome of rectal excision, and to reduce the length of stay in hospital and morbidity after surgery. It may facilitate proctectomy that would be difficult by an open or laparoscopic approach in people with a narrow pelvis or high body mass index, or where the position of the tumour is low in the rectum.

Implantation of a shock or load absorber for mild to moderate symptomatic medial knee osteoarthritis (IPG512)

Recommendations

1.1 Current evidence on the safety and efficacy of implantation of a shock or load absorber for mild to moderate symptomatic medial knee osteoarthritis is inadequate in quantity and quality. Therefore, this procedure should only be **used in the context of research**.

1.2 Further research into implantation of a shock or load absorber for mild to moderate symptomatic medial knee osteoarthritis should include comparative studies against existing forms of management. Studies should record patient selection, functional outcomes, quality of life and complications. They should also report the nature and timing of any further surgery on the knee and the effect of removing the device. A minimum follow-up period of 2–3 years is needed. NICE may update the guidance on publication of further evidence.

The procedure

The aim of this procedure is to lighten the load on the knee when the person is standing by inserting a load absorber. This reduces pain and potentially delays the need for

	further surgery. The device is implanted subcutaneously outside the knee joint, along its medial aspect. It is secured to the femur and tibia. It is intended to keep surrounding structures including bone, muscle and ligaments intact, allowing subsequent surgery to be performed if necessary. The device can be removed at a later date.
Medical Technologies Guidance	**The Sherlock 3CG Tip Confirmation System for placement of peripherally inserted central catheters (MTG24)** **Background** A peripherally inserted central catheter, or PICC, is a hollow tube inserted through a large vein in or near the arm. Many PICCs are placed using blind insertion (that is, with no mechanical guidance), and then a chest X-ray is taken to ensure the PICC is in the correct position before it is used. These X-rays can delay the start of treatment or monitoring. Using real-time tracking of the PICC tip, the Sherlock 3CG TCS allows the person placing the PICC to make sure it is in the correct position. NICE has said that the Sherlock 3CG TCS can be used instead of blind insertion to aid PICC placement, and in most cases it avoids the need for the confirmatory chest X-ray. **Recommendations** 1.1 The case for adopting the Sherlock 3CG Tip Confirmation System for placement of peripherally inserted central catheters is supported by the evidence. The technology usually avoids the need for a confirmatory chest X-ray in patients who would otherwise have blind insertion, minimising the delay before the catheter can be used for infusion. Using the technology increases staff confidence during catheter insertion. 1.2 The Sherlock 3CG Tip Confirmation System should be considered as an option for placement of peripherally inserted central catheters in adults. For patients whose electrocardiogram does not show a P wave (for example, patients with atrial fibrillation), a chest X-ray will still be needed to confirm tip location of the peripherally inserted central catheter. 1.3 The cost of using the Sherlock 3CG Tip Confirmation System (TCS) is similar to that of blind insertion and subsequent chest X-ray in adults who need a peripherally inserted central catheter in a non-intensive care setting. When the Sherlock 3CG TCS is used instead of fluoroscopy, the estimated cost saving is £106 per patient. In an intensive care setting, where the rate of misplacement with blind insertion is generally higher, there is an estimated cost saving of £41 per patient per use of the Sherlock 3CG TCS and a confirmatory chest X-ray compared with using blind insertion and chest X-ray. All these cost savings are subject to some uncertainty and need to be considered in the context of the clinical benefits.
Diagnostics Guidance	**None published so far this month**
NICE Quality Standards	**Falls in older people: assessment after a fall and preventing further falls (QS86)** This quality standard covers assessment after a fall and preventing further falls (secondary prevention) in older people living in the community and during a hospital stay. Secondary prevention focuses on interventions targeted at older people with a history of falls. Older people are those aged 65 years and over. **Managing medicines in care home (QS85)** This quality standard covers the prescribing, handling and administering of medicines for all people (including adults, children and young people) living in care homes, and the provision of care or services relating to medicines to those people. **Physical activity: encouraging activity in all people in contact with the NHS (QS84)** This quality standard covers encouraging physical activity in people of all ages who are

	in contact with the NHS, including staff, patients and carers. It does not cover encouraging physical activity for particular conditions; this is included in condition-specific quality standards where appropriate. **Alcohol: preventing harmful alcohol use in the community (QS83)** This quality standard covers a range of approaches at a population level to prevent harmful alcohol use in the community by children, young people and adults. The statements are particularly relevant to trading standards, other local authority teams, the police, and schools and colleges. This quality standard does not cover screening and brief interventions, which are covered by NICE's quality standard on alcohol dependence and harmful alcohol use. **Smoking: reducing tobacco use (QS82)** This quality standard covers reducing tobacco use, including interventions to discourage people from taking up smoking, tobacco control strategies and smokefree policies. This quality standard does not cover referral to and delivery of stop smoking services, which are already covered by NICE's quality standard on smoking cessation: supporting people to stop smoking. This quality standard does not cover harm reduction approaches to smoking, which is being developed as a separate topic.
Commissioning Guides	**None published so far this month**
Public health briefings for local government	**None published so far this month**

Current NICE consultations with links and start and finish dates for stakeholders to make contribution

Title / link	Start date of consultation	End date of consultation
Bipolar disorder in adults: quality standard consultation	27/02/2015	27/03/2015
Dyspepsia: quality standard consultation	27/02/2015	27/03/2015
Depression in adults (update): scope consultation	02/03/2015	30/03/2015
Workplace health – older employees: call for evidence 2015	02/03/2015	27/03/2015
Drug misuse prevention: scope consultation	03/03/2015	01/04/2015
Transcranial direct current stimulation (TDCS) for depression: consultation	04/03/2015	31/03/2015
Home care: guideline consultation	05/03/2015	16/04/2015
Coeliac disease: guideline consultation	06/03/2015	21/04/2015
Gallstone disease: topic engagement exercise	06/03/2015	27/03/2015
Maternal and child nutrition – improving nutritional status: quality standards consultation	06/03/2015	07/04/2015
Workplace health: policies and approaches to support employees with disabilities and long-term conditions: scope consultation	06/03/2015	07/04/2015
Cardiovascular risk assessment: quality standard consultation	09/03/2015	08/04/2015
Lipid modification: quality standard consultation	09/03/2015	08/04/2015
Secondary prevention of myocardial infarction: quality standard consultation	09/03/2015	08/04/2015
Drug allergy – diagnosis and management: quality standard consultation	12/03/2015	13/04/2015
Knee cartilage defects – autologous chondrocyte implantation [ID686]: appraisal consultation	12/03/2015	07/04/2015
New generation cardiac CT scanners (Aquilion ONE, Brilliance iCT, Discovery CT750 HD and Somatom Definition Flash): review proposal – March 2015	12/03/2015	02/04/2015
CG65 Perioperative hypothermia (inadvertent): surveillance review proposal – March 2015	16/03/2015	27/03/2015
The 3M Tegaderm CHG IV securement dressing for central venous and arterial catheter insertion sites: consultation	18/03/2015	19/04/2015
Endometriosis: consultation on the draft scope	20/03/2015	21/04/2015
Bladder Cancer: topic engagement exercise	23/03/2015	08/04/2015
Chronic obstructive pulmonary disease (QS update): topic engagement exercise	23/03/2015	08/04/2015
Management and organisational approaches to safe staffing: consultation on the draft scope	25/03/2015	22/04/2015
Cervical ripening and dilation with double balloon catheter for facilitating induction of labour in pregnant women without a previous caesarean section: consultation	26/03/2015	27/04/2015
Preoperative high dose rate brachytherapy for rectal cancers: consultation	26/03/2015	27/04/2015

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