NICE Update Bulletin December 2016
issued Wednesday 21 December 2016

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)	**Dasatinib, nilotinib and imatinib for untreated chronic myeloid leukaemia TA426** This guidance is a Cancer Drugs Fund reconsideration of dasatinib, nilotinib and standard-dose imatinib for the first-line treatment of chronic myeloid leukaemia (TA251). This guidance replaces TA251 and partially updates NICE technology appraisal guidance on imatinib for chronic myeloid leukaemia (TA70). **Recommendations** 1.1 Imatinib is recommended as an option for untreated, chronic-phase Philadelphia-chromosome-positive chronic myeloid leukaemia in adults. 1.2 Dasatinib and nilotinib are recommended, within their marketing authorisations, as options for untreated chronic-phase Philadelphia-chromosome-positive chronic myeloid leukaemia in adults. The drugs are recommended only if the companies provide them with the discounts agreed in the relevant patient access schemes. **The technology** Dasatinib (Sprycel, Bristol-Myers Squibb), a tyrosine kinase inhibitor, is an orally active inhibitor of Src and the Src family of tyrosine kinases. These are involved in cell growth, differentiation, migration and survival, and many are involved in oncogenesis, tumour metastasis and angiogenesis. Imatinib (Glivec, Novartis Pharmaceuticals) is an orally active tyrosine kinase inhibitor, designed to competitively inhibit Bcr-Abl tyrosine kinase activity. By blocking specific signals in cells expressing Bcr-Abl, imatinib reduces the uncontrolled proliferation of white blood cells that is a characteristic feature of chronic myeloid leukaemia (CML). Nilotinib (Tasigna, Novartis Pharmaceuticals), a tyrosine kinase inhibitor, is an orally active phenylaminopyrimidine derivative of imatinib. Studies suggest that nilotinib inhibits 32 of 33 mutant Bcr-Abl forms that are resistant to imatinib. **Financial factors** This technology is commissioned by NHS England. Previously, imatinib and nilotinib, with a patient access scheme, were recommended in NICE technology appraisal guidance (TA251). Dasatinib was not recommended. After this Cancer Drugs Fund partial reconsideration of TA251, dasatinib with a patient access scheme is now recommended as an option for untreated chronic-phase Philadelphia-chromosome-positive chronic myeloid leukaemia in adults. The option of dasatinib represents a further treatment option for this patient population that is unlikely to have a significant impact on resources. **Dasatinib, nilotinib and high-dose imatinib for treating imatinib-resistant or intolerant chronic myeloid leukaemia TA425** This guidance is a Cancer Drugs Fund reconsideration of dasatinib, high-dose imatinib and nilotinib for the treatment of imatinib-resistant chronic myeloid leukaemia (CML) (part review of NICE technology appraisal guidance 70), and dasatinib and nilotinib for people with CML for whom treatment with imatinib has failed because of intolerance (TA241). This guidance replaces TA241, and partially updates NICE technology appraisal guidance on imatinib for chronic myeloid leukaemia (TA70). **Recommendations** 1.1 Dasatinib and nilotinib are recommended as options for treating only chronic- or accelerated-phase Philadelphia-chromosome-positive chronic myeloid leukaemia

in adults, if:

- they cannot have imatinib, or their disease is imatinib-resistant and
- the companies provide the drugs with the discounts agreed in the relevant patient access schemes.

1.2 High-dose imatinib (that is, 600 mg in the chronic phase or 800 mg in the accelerated and blast-crisis phases) is not recommended for treating Philadelphia-chromosome-positive chronic myeloid leukaemia in adults whose disease is imatinib-resistant.

1.3 This guidance is not intended to affect the position of patients whose treatment with imatinib or dasatinib was started within the NHS before this guidance was published. Treatment of those patients may continue without change to whatever funding arrangements were in place for them before this guidance was published until they and their NHS clinician consider it appropriate to stop.

The technology

Dasatinib (Sprycel, Bristol-Myers Squibb), a tyrosine kinase inhibitor, is an orally active inhibitor of Src and the Src family of tyrosine kinases. These are involved in cell growth, differentiation, migration and survival, and many are involved in oncogenesis, tumour metastasis and angiogenesis.

Imatinib (Glivec, Novartis Pharmaceuticals) is an orally active tyrosine kinase inhibitor, designed to competitively inhibit Bcr-Abl tyrosine kinase activity. By blocking specific signals in cells expressing Bcr-Abl, imatinib reduces the uncontrolled proliferation of white blood cells that is a characteristic feature of chronic myeloid leukaemia (CML).

Nilotinib (Tasigna, Novartis Pharmaceuticals), a tyrosine kinase inhibitor (TKI), is an orally active phenylaminopyrimidine derivative of imatinib. Studies suggest that nilotinib inhibits 32 of 33 mutant Bcr-Abl forms that are resistant to imatinib.

Financial factors

This technology is commissioned by NHS England. NICE states that any movement between dasatinib and nilotinib for people currently treated in routine commissioning is unlikely to have a significant resource impact because they are similarly priced. In most people on imatinib treatment, it is anticipated that resistance will develop in the chronic stage because the accelerated phase is quite rare. People who have first-line treatment with imatinib, in whom resistance develops in the chronic phase, will be treated with dasatinib for an average of 5 years.

Dasatinib will be available through routine commissioning and there will be a resource impact for NHS England specialised commissioning. Dasatinib will no longer be funded through the CDF from the date of publication of this guidance on 21 December 2016.

Pertuzumab for the neoadjuvant treatment of HER2-positive breast cancer TA424

Recommendations

1.1 Pertuzumab, in combination with trastuzumab and chemotherapy, is recommended, within its marketing authorisation, as an option for the neoadjuvant treatment of adults with human epidermal growth factor receptor 2 (HER2)-positive breast cancer; that is, in patients with HER2-positive, locally advanced, inflammatory or early-stage breast cancer at high risk of recurrence. It is recommended only if the company provides pertuzumab with the discount agreed in the patient access scheme.

The technology

Pertuzumab (Perjeta, Roche) is a recombinant monoclonal antibody which targets human epidermal growth factor receptor 2 (HER2)-positive breast tumours. It interrupts the activation of the HER2 intracellular signalling pathway, leading to cell growth arrest and apoptosis. It is administered by intravenous infusion.

Pertuzumab has a marketing authorisation in the UK 'in combination with trastuzumab and chemotherapy for the neoadjuvant treatment of adult patients with HER2-positive, locally advanced, inflammatory, or early-stage breast cancer at high risk of recurrence'.

Financial factors

This technology is commissioned by NHS England. Neoadjuvant therapy is the administration of therapeutic agents before a main treatment. In breast cancer this is usually used before surgery to attempt to shrink the tumour. NICE estimates that approximately 1,600 people in England are eligible for treatment with neoadjuvant pertuzumab each year. From year 2 it is estimated that 1,100 people will have treatment with neoadjuvant pertuzumab each year once uptake has reached 70%.

Eribulin for treating locally advanced or metastatic breast cancer after 2 or more chemotherapy regimens TA423

This guidance replaces NICE technology appraisal guidance on eribulin for the treatment of locally advanced or metastatic breast cancer (TA250).

Recommendations

1.1 Eribulin is recommended as an option for treating locally advanced or metastatic breast cancer in adults, only when:

- it has progressed after at least 2 chemotherapy regimens (which may include an anthracycline or a taxane, and capecitabine)
- the company provides eribulin with the discount agreed in the patient access scheme.

1.2 This guidance is not intended to affect the position of patients whose treatment with eribulin was started within the NHS before this guidance was published. Treatment of those patients may continue without change to whatever funding arrangements were in place for them before this guidance was published until they and their NHS clinician consider it appropriate to stop.

The technology

Eribulin (Halaven, Eisai) is a synthetic analogue of halichondrin B, which inhibits tubulin polymerisation. This disrupts the assembly and formation of microtubules, stopping cancer cell division. Eribulin has a UK marketing authorisation for the treatment of adult patients with locally advanced or metastatic breast cancer who have progressed after at least 1 chemotherapeutic regimen for advanced disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting unless these treatments were not suitable.

Financial factors

This technology is commissioned by NHS England. The technology will be available through routine commissioning and there will be a resource impact for specialised commissioning. Eribulin will no longer be funded through the CDF from the date of publication of this guidance on 21 December 2016.

Crizotinib for previously treated anaplastic lymphoma kinase-positive advanced non-small-cell lung cancer TA422

This guidance is a Cancer Drugs Fund (CDF) reconsideration of crizotinib for previously treated non-small-cell lung cancer associated with an anaplastic lymphoma kinase fusion gene (TA296). This guidance replaces TA296.

Recommendations

1.1 Crizotinib is recommended, within its marketing authorisation, as an option for previously treated anaplastic lymphoma kinase-positive advanced non-small-cell lung cancer in adults. The drug is recommended only if the company provides it with the discount agreed in the patient access scheme.

The technology

Crizotinib (Xalkori, Pfizer) is an inhibitor of the anaplastic lymphoma kinase (ALK) tyrosine kinase receptor and its variants. It has a marketing authorisation in the UK which includes 'adults with previously treated ALK-positive advanced non-small-cell lung cancer'.

Financial factors

This technology is commissioned by NHS England. This guidance is not expected to have a significant impact on resources because the population for previously treated anaplastic lymphoma kinase-positive advanced non-small-cell lung cancer is small.

Crizotinib has been available as first-line treatment since September 2016. The technology was previously funded through the CDF. Crizotinib will not be funded through the CDF from the date of publication of this guidance on 21 December 2016.

Everolimus with exemestane for treating advanced breast cancer after endocrine therapy TA421

This guidance is a Cancer Drugs Fund reconsideration of everolimus in combination with exemestane for treating advanced HER2-negative hormone receptor-positive breast cancer after endocrine therapy (TA295). This guidance replaces TA295.

Recommendations

1.1 Everolimus, in combination with exemestane, is recommended within its marketing authorisation, as an option for treating advanced human epidermal growth factor receptor 2 (HER2)-negative, hormone-receptor-positive breast cancer in postmenopausal women without symptomatic visceral disease that has recurred or progressed after a non-steroidal aromatase inhibitor. Everolimus is recommended only if the company provides it with the discount agreed in the patient access scheme.

The technology

Everolimus (Afinitor, Novartis Pharmaceuticals) inhibits the mammalian target of rapamycin, a protein that regulates the division of tumour cells and growth of blood vessels. It has a UK marketing authorisation for the 'treatment of hormone receptor-positive, HER2/neu negative advanced breast cancer, in combination with exemestane, in postmenopausal women without symptomatic visceral disease after recurrence or progression following a non-steroidal aromatase inhibitor'.

Financial factors

This technology is commissioned by NHS England. The technology will be available through routine commissioning and there will be a resource impact for specialised commissioning. The technology was previously funded through the CDF. Everolimus will not be funded through the CDF from the date of publication of this guidance on 21 December 2016.

Ticagrelor for preventing atherothrombotic events after myocardial infarction TA420

Recommendations

1.1 Ticagrelor, in combination with aspirin, is recommended within its marketing authorisation as an option for preventing atherothrombotic events in adults who had a myocardial infarction and who are at high risk of a further event.

Treatment should be stopped when clinically indicated or at a maximum of 3 years.

The technology

Ticagrelor is an oral antagonist of the P2Y12 adenosine diphosphate receptor that inhibits platelet aggregation and thrombus formation in atherosclerotic disease. Ticagrelor 60 mg twice daily, co-administered with aspirin (acetylsalicylic acid), has a marketing authorisation for 'the prevention of atherothrombotic events in adult patients with a history of myocardial infarction of at least 1 year and a high risk of developing an atherothrombotic event'.

Financial factors

This technology is commissioned by CCGs. NICE estimates the annual cost associated with implementing the guidance from 2022/23 (once a steady state reached) is equivalent to £15,600 per 100,000 population. More people having ticagrelor 60 mg is likely to result in more adverse events but fewer atherothrombotic events.

Highly specialised technology guidance (HSTs)	**None published so far this month**
NICE Guidelines (NGs)	**End of life care for infants, children and young people with life-limiting conditions: planning and management NG61** This guideline covers the planning and management of end of life and palliative care for infants, children and young people (aged 0–17 years) with life-limiting conditions. It aims to involve children, young people and their families in decisions about their care, and improve the support that is available to them throughout their lives. This guideline includes recommendations on: • Advance Care Planning • emotional and psychological support and interventions • managing distressing symptoms, such as pain, agitation, seizures or respiratory distress • hydration and nutrition • recognising that a child or young person is likely to die within hours or days • care and support for parents, carers and healthcare professionals after the death of a child or young person • care at home **HIV testing: increasing uptake among people who may have undiagnosed HIV (Joint NICE and Public Health England guideline) NG60** This guideline covers how to increase the uptake of HIV testing in primary and secondary care, specialist sexual health services and the community. It describes how to plan and deliver services that are tailored to the local prevalence of HIV, promote awareness of HIV testing and increase opportunities to offer testing to people who may have undiagnosed HIV. This guideline includes recommendations on: • offering and recommending HIV testing in different settings • increasing opportunities for HIV testing • promoting awareness and uptake of HIV testing • reducing barriers to HIV testing **Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation CG135 (update)** This guideline covers identifying people who wish to donate their organs after their death. It offers advice on how to approach families and carers of people who are nearing the end of life and how to seek consent for organ donation. It aims to promote discussion of organ donation as part of end-of-life care and to increase the number of organs available for people waiting for a transplant. **December 2016:** A footnote on diagnosis of brain stem death in infants was added to recommendation 1.1.2. A footnote on the NHS Organ Donor Register was added to recommendation 1.1.9. An outdated research recommendation was removed. **Intravenous fluid therapy in adults in hospital CG174 (update)** This guideline covers the general principles for managing intravenous (IV) fluid therapy in hospital inpatients aged 16 and over with a range of conditions. It aims to help prescribers understand the optimal amount and composition of IV fluids to be administered and the best rate at which to give them, to improve fluid prescribing and outcomes among people in hospital. It does not cover pregnant women, and those with severe liver or renal disease, diabetes or burns.

December 2016: A footnote was added to recommendations 1.4.1 and 1.4.4, the tables on 'Consequences of fluid mismanagement to be reported as critical incidents' and 'IV fluid prescription (by body weight) for routine maintenance over a 24 hour period' and the accompanying algorithms giving more information on weight-based potassium prescriptions.

Hypothermia: prevention and management in adults having surgery CG65 (update)

This guideline covers preventing and managing inadvertent hypothermia in people aged 18 and over having surgery. It offers advice on assessing patients' risk of hypothermia, measuring and monitoring temperature, and devices for keeping patients warm before, during and after surgery.

December 2016: NICE reviewed the evidence on measuring temperature, warming patients before induction of anaesthesia and warming patients after induction of anaesthesia. They changed and added some recommendations in sections 1.1, 1.2 and 1.3.

The following NICE Guidelines and updates were published at the end of November, after publication of the November bulletin:

Low back pain and sciatica in over 16s: assessment and management NG59

This guideline covers assessing and managing low back pain and sciatica in people aged 16 and over. It outlines physical, psychological, pharmacological and surgical treatments to help people manage their low back pain and sciatica in their daily life. The guideline aims to improve people's quality of life by promoting the most effective forms of care for low back pain and sciatica.

This guideline includes recommendations on:

- assessment of low back pain and sciatica
- non-invasive treatments for low back pain and sciatica
- invasive treatments for low back pain and sciatica.

Coexisting severe mental illness and substance misuse: community health and social care services NG58

This guideline covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse. The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.

This guideline includes recommendations on:

- first contact with services
- referral to secondary care mental health services
- the care plan: multi-agency approach to address physical health, social care, housing and other support needs
- partnership working between specialist services, health, social care and other support services and commissioners
- improving service delivery
- maintaining contact between services and people with coexisting severe mental illness and substance misuse who use them.

Chest pain of recent onset: assessment and diagnosis CG95 (update)

This guideline covers assessing and diagnosing recent chest pain in people aged 18 and over and managing symptoms while a diagnosis is being made. It aims to improve outcomes by providing advice on tests (ECG, high-sensitivity troponin tests, multislice CT angiography, functional testing) that support healthcare professionals to make a speedy and accurate diagnosis.

November 2016: NICE reviewed the evidence for high-sensitivity troponin tests, non-invasive imaging and exercise ECG for adults with acute chest pain, and diagnostic

	testing for adults with stable chest pain. They changed and added some recommendations in section 1.2 and section 1.3. **Spasticity in under 19s: management CG145 (update)** This guideline covers managing spasticity and co-existing motor disorders and their early musculoskeletal complications in children and young people (from birth up to their 19th birthday) with non-progressive brain disorders. It aims to reduce variation in practice and help healthcare professionals to select and use appropriate treatments. **November 2016:** Recommendation 1.1.8 was amended to update information on the World Health Organization's International Classification of Functioning, Disability and Health (ICF) and the domains it covers.
Interventional Procedures Guidance (IPGs)	**Radiation therapy for early Dupuytren's disease IPG573** **Recommendations** 1.1 The evidence on radiation therapy for early Dupuytren's disease raises no major safety concerns. Current evidence on its efficacy is inadequate in quantity and quality, and is difficult to interpret because of uncertainty about the natural history of Dupuytren's disease. Therefore, this procedure should only be used with **special arrangements** for clinical governance, consent and audit or research. 1.2 Clinicians wishing to do radiation therapy for early Dupuytren's disease should: • Inform the clinical governance leads in their NHS trusts. • Ensure that patients understand the uncertainty about the procedure's efficacy, the unpredictability of progression of early Dupuytren's disease, and that there is a theoretical risk of malignancy in the long term after any type of radiation therapy. Clinicians should provide patients with clear written information. In addition, the use of NICE's information for the public is recommended. • Audit and review clinical outcomes of all patients having radiation therapy for early Dupuytren's disease (see section 7.1). 1.3 NICE encourages further research into radiation therapy for early Dupuytren's disease, including randomised controlled trials. Because of the uncertainty over the natural history of the disease, this should include studies comparing the long-term efficacy of radiation therapy with no radiation therapy. Studies should include details of patient selection, stage of disease progression, duration and types of treatment, patient-reported outcomes, and long-term efficacy and safety data. NICE may update the guidance on publication of further evidence. **The procedure** In Dupuytren's disease, connective tissue in the palm of the hands thickens. This causes nodules (small, hard lumps) to form under the skin of the palm. Over time, the nodules can form cords of tissue. These cords can shorten and permanently bend the fingers towards the palm, reducing hand mobility and causing pain. Often, Dupuytren's disease is mild and doesn't need treatment. But treatment may help if the condition stops the hand working normally. It includes injections with a medication called collagenase, a needle to cut the contracted cords of tissue (needle fasciotomy) or, in severe cases, surgery. NICE has looked at using radiation therapy as another treatment option. Radiation therapy for early Dupuytren's disease involves directing low energy X-rays at the affected tissue. The aim is to stop the disease getting worse. Usually, 10 doses of radiation are given in 2 phases, with the second phase given after a 6- to 12-week gap. Or, 7 doses are given on alternate days over 2 weeks. **Irreversible electroporation for treating prostate cancer IPG572** **Recommendations** 1.1 Current evidence on the safety and efficacy of irreversible electroporation for treating prostate cancer is inadequate in quantity and quality. Therefore, this procedure should only be used **in the context of research**. Studies should include randomised controlled trials comparing the procedure with current standards of care. They should report details of patient selection and short- and long-term

outcomes, including patient-reported outcomes and the effect on any future prostate surgery.

The procedure

The prostate is a small gland near a man's bladder. Cancer in the prostate gland usually develops slowly. Symptoms include difficulties in passing urine, but the disease is often diagnosed before symptoms develop. Treatments include 'watching and waiting', radiotherapy, freezing (cryotherapy), high-intensity focused ultrasound, medication and surgery.

NICE has looked at using irreversible electroporation as another treatment option. In this procedure, needles are inserted through the skin into the tumour and electrical pulses are passed through them to destroy the cancer cells. It is done using general anaesthetic. The electrical pulses can travel through the body and affect the heart. The electrical pulses have to be timed so that they do not affect the heart's normal rhythm.

Extracorporeal shockwave therapy for Achilles tendinopathy IPG571

Recommendations

1.1 The evidence on extracorporeal shockwave therapy (ESWT) for Achilles tendinopathy raises no major safety concerns. Current evidence on efficacy of the procedure is inconsistent and limited in quality and quantity. Therefore, ESWT for Achilles tendinopathy should only be used with **special arrangements** for clinical governance, consent and audit or research.

1.2 Clinicians wishing to do ESWT for Achilles tendinopathy should:

- Inform the clinical governance leads in their NHS trusts.
- Ensure that patients understand the uncertainty about the procedure's efficacy and provide them with clear written information. In addition, the use of NICE's information for the public is recommended.
- Audit and review clinical outcomes of all patients having ESWT for Achilles tendinopathy (see section 7.2).

1.3 NICE encourages further research into ESWT for Achilles tendinopathy, which may include comparative data collection. Studies should clearly describe patient selection, treatment protocols, use of local anaesthesia and the type and duration of energy applied (see section 3). Studies should include validated outcome measures and have a minimum of 1 year of follow-up. NICE may update the guidance on publication of further evidence.

The procedure

Achilles tendinopathy is pain and inflammation of the tendon at the back of the heel. It is usually caused by injury or overuse. Symptoms include pain, swelling, weakness and stiffness, and tenderness over the heel.

Tendinopathy usually gets better either on its own or with the help of rest, applying ice and treatments such as corticosteroid injections, orthotics, physiotherapy, physical exercises or stretching and pain relief medications. If these don't work, surgery may sometimes be considered. NICE has looked at using extracorporeal shockwave therapy as another treatment option. In extracorporeal shockwave therapy, a device is used to pass acoustic shockwaves through the skin to the affected area. This is thought to stimulate healing, but it is not known how this works. There are low-energy and high-energy devices available. High-energy devices may cause more pain, needing local anaesthetic. There is some evidence that local anaesthetic may reduce the benefit of the procedure. Low-energy devices cause less pain, can be used repeatedly and doesn't need local anaesthetic. Many patients have a series of treatments but it may be a single session. Ultrasound guidance may be used to help position the device.

Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica IPG570

Recommendations

1.1 Current evidence on the safety and efficacy of epiduroscopic lumbar discectomy through the sacral hiatus for sciatica is limited in quantity and quality. Therefore, this procedure should only be used **in the context of research**.

	1.2 This procedure should only be done by surgeons with expertise in endoscopic spinal surgery and specific training in epiduroscopy through the sacral hiatus. 1.3 NICE encourages further research into epiduroscopic lumbar discectomy through the sacral hiatus for sciatica and may update the guidance on publication of further evidence. Research studies should include details of patient selection, complications and long-term results. **The procedure** The tough outer cover of a disc is called the annulus. It can sometimes weaken or tear, allowing the soft centre to bulge through. This is called herniation, also known as a 'slipped disc'. If it presses on a nerve, the slipped disc can cause pain in the back, pain in the leg (sciatica), and numbness or paralysis in the legs or even problems with the bladder or bowel. Treatments include painkillers, drugs to reduce inflammation, corticosteroid injections into the affected area, and physical therapy. If these treatments don't work, or if the symptoms are severe or long lasting, the part of the slipped disc that is pressing on the nerve may be removed, either by open surgery or using less invasive techniques. This is called discectomy. NICE has looked at using epiduroscopic lumbar discectomy through the sacral hiatus as another treatment option. This is usually done with the patient under sedation and local anaesthesia. The aim is to relieve the pain of sciatica by removing the parts of the disc that press against the spinal nerve.
Medical Technologies Guidance	**XprESS multi sinus dilation system for treating chronic sinusitis MTG30** **Recommendations** 1.1 The case for adopting the XprESS multi-sinus dilation system for treating uncomplicated chronic sinusitis after medical treatment has failed is supported by the evidence. Treatment with XprESS leads to a rapid and sustained improvement in chronic symptoms, fewer acute episodes and improved quality of life which is comparable to functional endoscopic sinus surgery (FESS). 1.2 XprESS should be considered in patients with uncomplicated chronic sinusitis who do not have severe nasal polyposis. In these patients, XprESS works as well as FESS, is associated with faster recovery times, and can more often be done under local anaesthesia. 1.3 Cost modelling indicates that XprESS is cost saving compared with FESS when treatment is done using local anaesthetic in an outpatient setting. The estimated saving per patient is £152, assuming that 80% of treatments are done this way, FESS takes 60 minutes and the device cost for XprESS is £820. By adopting this technology, the NHS in England may save around £7.4 million a year by 2020. Estimated savings are mainly achieved through the shift of treatment from operating theatre to outpatient setting. **Financial factors** This technology is commissioned by CCGs. NICE indicates that XprESS is cost saving compared with FESS when treatment is done using local anaesthetic in an outpatient setting. Estimated savings are mainly achieved through the shift of treatment from operating theatre to outpatient setting.
Diagnostics Guidance	**None published so far this month**
NICE Quality Standards	**Transition from children's to adults' services QS140** This quality standard covers all young people (aged up to 25) using children's health and social care services who are due to make the transition to adults' services. It includes young people: • with mental health problems • with disabilities

- with long-term, life-limiting or complex needs
- in secure settings
- under the care of local authorities.

Some young people may only enter children's health or social care services shortly before they transfer to adults' services. They are within the scope of the quality standard, providing they are using children's services at the time of their transfer to adults' services.

Oral health promotion in the community QS139

This quality standard covers activities undertaken by local authorities and general dental practices to improve oral health. It particularly focuses on people at high risk of poor oral health or who find it difficult to use dental services. It describes high-quality care in priority areas for improvement.

Blood transfusion QS138

This quality standard covers the general principles of blood transfusion in adults, young people and children over 1 year old. It describes high-quality care in priority areas for improvement. It does not cover specific conditions that blood transfusion is used for.

Mental wellbeing and independence for older people QS137

This quality standard covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older, and how to identify those at risk of a decline. It describes high-quality care in priority areas for improvement. It does not cover the mental wellbeing and independence of people who live in a care home or attend one on a day-only basis.

Transition between inpatient hospital settings and community or care home settings for adults with social care needs QS136

This quality standard covers admissions into, and discharge from, inpatient hospital settings for adults (aged 18 years and over) with social care needs. It describes high-quality care in priority areas for improvement.

The following updated NICE Quality Standard was published at the end of November, after publication of the November bulletin:

Hip fracture in adults QS16 (update)

This quality standard covers the diagnosis and management of hip fracture in adults (aged 18 years and over). It describes high-quality care in priority areas for improvement. It does not cover the prevention of hip fracture, which is covered in osteoporosis and falls in older people.

November 2016: this quality standard was updated in response to an annual review, which identified changes in the areas for improvement for this topic.

Produced by
Rebecca Heayn (Clinical Effectiveness Governance Manager),
NEW Devon CCG Clinical Effectiveness and Medicines Optimisation Team
County Hall, Topsham Road, Exeter, EX2 4QL

For distribution Northern, Eastern and Western Devon CCG & South Devon and Torbay CCG

Current NICE consultations with links and end dates for stakeholders to contribute

Title / link	End date of consultation
Osteoporosis: Quality Standard consultation	03/01/2017
Cerebral palsy in adults: Draft scope consultation	05/01/2017
Familial breast cancer (standing committee update): Addendum consultation	05/01/2017
Lymphoma (Hodgkin's, CD30-positive) - brentuximab vedotin [ID722] : Appraisal consultation : 2	12/01/2017
Eating disorders – recognition and treatment: Draft guidance consultation	20/01/2017
Alcohol-use disorders: diagnosis and management of physical complications (standing committee update) : Addendum consultation	24/01/2017
Air pollution – outdoor air quality and health: Draft guidance consultation	25/01/2017
Liver disease: Quality Standard consultation	06/02/2017