NHS Devon

NICE Update Bulletin: April 2024

This bulletin includes details of the following new and updated NICE guidance – click on the titles below for further details:

1. **Gefapixant for treating refractory or unexplained chronic cough *(terminated appraisal)* TA969**
2. **Melphalan flufenamide with dexamethasone for treating relapsed or refractory multiple myeloma (*terminated appraisal*) TA968**
3. **Pembrolizumab with gemcitabine and cisplatin for untreated advanced biliary tract cancer (*terminated appraisal*) TA966**
4. **Cabozantinib with nivolumab for untreated advanced renal cell carcinoma TA964**
5. **Dostarlimab with platinum-based chemotherapy for treating advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency TA963**
6. **Twin and triplet pregnancy NG137 (UPDATE)**
7. **Endometriosis: diagnosis and management NG73 (UPDATE)**
8. **Lymphovenous anastomosis during axillary or inguinal node dissection for preventing secondary lymphoedema IPG785**
9. **Epidermal radiotherapy using rhenium-188 paste for non-melanoma skin cancer IPG784**
10. **GaitSmart rehabilitation exercise programme for gait and mobility issues MTG78**
11. **Kurin Lock for blood culture collection MTG77**
12. **Digital technologies to deliver pulmonary rehabilitation programmes for adults with COPD: early value assessment HTE18**
13. **Current NICE Consultations**

Technology Appraisals (TAs)

Gefapixant for treating refractory or unexplained chronic cough *(terminated appraisal)* TA969

NICE is **unable to make a recommendation** on gefapixant for treating refractory or unexplained chronic cough in adults. This is because the company did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Melphalan flufenamide with dexamethasone for treating relapsed or refractory multiple myeloma (*terminated appraisal*) TA968

NICE is **unable to make a recommendation** on melphalan flufenamide for treating relapsed or refractory multiple myeloma in adults. This is because the company did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Pembrolizumab with gemcitabine and cisplatin for untreated advanced biliary tract cancer (*terminated appraisal*) TA966

NICE is **unable to make a recommendation** on pembrolizumab with gemcitabine and cisplatin for untreated advanced biliary tract cancer in adults. This is because the company did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Cabozantinib with nivolumab for untreated advanced renal cell carcinoma TA964

Recommendations

Cabozantinib with nivolumab is **recommended** as an option for untreated advanced renal cell carcinoma in adults, only if:

- their disease is intermediate or poor risk as defined in the International Metastatic Renal Cell Carcinoma Database Consortium criteria, and
- nivolumab with ipilimumab or lenvatinib with pembrolizumab would otherwise be offered, and
- the companies provide cabozantinib and nivolumab according to their commercial arrangements.

This recommendation is not intended to affect treatment with cabozantinib with nivolumab that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

The Technology

Renal cell carcinoma (RCC) is a cancer that usually originates in the lining of the tubules of the kidney that help filter the blood and make urine. RCC is the most common type of kidney cancer, accounting for more than 80% of cases. There are several types of RCC. The main ones are clear cell, papillary and chromophobe. Treatment depends on the location and stage of the cancer. There are different staging systems for renal cell carcinoma, including the number system. It looks at the number and size of kidney tumours. The number system has 4 stages:

- Stage 1 and 2 (early stage where tumour is localised to the kidney)
- Stage 3 (locally advanced stage with possible spread to regional lymph nodes)
- Stage 4 (advanced, metastatic stage where tumour has spread beyond regional lymph nodes to other parts of the body)

Early stage RCC is localised to the kidneys. Treatment options for localised tumours include laparoscopic or open surgery, which can be partial or total, and ablation techniques including radiofrequency ablation, microwave ablation, cryoablation and stereotactic body radiation therapy (SABR). These are performed with curative intent. Nephrectomy is the only treatment option for locally advanced RCC. After tumour resection, the cancer can be graded. **TA830** is recommended for adjuvant treatment after nephrectomy to those whose cancer is at increased risk of recurrence.

NICE have a published several TAs with recommendations for advanced, metastatic first line, advanced, metastatic second line, advanced, metastatic, third line and advanced, metastatic fourth line: **TA169**, **TA215**, **TA512**, **TA645**, **TA542**, **TA780**, **TA858**, **TA333**, **TA463**, **TA498**, **TA417**, **TA432**.

Financial Factors

This technology is commissioned by NHS England.

There are no clinical trials directly comparing cabozantinib plus nivolumab with treatments other than sunitinib. An indirect comparison suggests that people who have cabozantinib plus nivolumab have more time before their cancer gets worse than pazopanib or tivozanib. It also suggests that cabozantinib plus nivolumab works as well as nivolumab plus ipilimumab and lenvatinib plus pembrolizumab. But these results are uncertain because of the evidence and methods used in the indirect comparison.

For favourable-risk cancer, the cost-effectiveness estimates are above what NICE normally considers an acceptable use of NHS resources. For intermediate- and poor-risk cancer, the cost-effectiveness estimates are uncertain. But the most likely estimates for cabozantinib plus nivolumab compared with lenvatinib plus pembrolizumab and nivolumab plus ipilimumab are within the range that NICE normally considers an acceptable use of NHS resources. Therefore, cabozantinib plus nivolumab is recommended for people with intermediate- and poor-risk cancer if nivolumab plus ipilimumab or lenvatinib plus pembrolizumab would have otherwise been offered.

The companies have commercial arrangements. These make cabozantinib and nivolumab available to the NHS with discounts.

NICE estimate that in Devon, 25 people will be eligible for treatment.

Dostarlimab with platinum-based chemotherapy for treating advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency TA963

Recommendations

Dostarlimab with platinum-based chemotherapy is **recommended** with **managed access** as an option for treating primary advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency in adults who are candidates for systemic therapy. It is only recommended if the conditions in the managed access agreement for dostarlimab are followed.

This recommendation is not intended to affect treatment with dostarlimab with platinum-based chemotherapy that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

The Technology

Endometrial cancer is a cancer of the lining of the womb, known as the endometrium. It is the most common type of womb cancer, often diagnosed in the earlier stages. When diagnosed, endometrial cancer is categorised between stage 1 and 4. Advanced endometrial cancer is defined as stage 3 or 4, where the cancer has spread outside the womb. In stage 3, the spread of cancer is contained within the pelvis. Once the cancer has spread into another area of the body, it is classed as stage 4 or metastatic (stages 3 and 4 are known as advanced cancer). Recurrent endometrial cancer is when the cancer returns after primary treatment. The cancer can recur anywhere, commonly in the abdominal cavity, lymph nodes, lung and vagina. The symptoms of recurrence and advanced stage disease are variable but include abdominal pain, bloating, nausea, shortness of breath, vaginal bleeding and changes in bowel or bladder habits.

The first treatment for endometrial cancer is usually to remove the womb (hysterectomy) and both the fallopian tubes and ovaries (bilateral salpingo-oophorectomy). In advanced endometrial cancer, debulking surgery may be carried out to remove as much of the cancer as possible. Radiotherapy may be used for people who cannot have surgery, or alongside surgical treatment. Chemotherapy can be used adjunct to surgery for people with stage 2-4 disease. Hormone therapy or chemotherapy may be used for cancer that has metastasised or relapsed.

Dostarlimab with platinum-containing chemotherapy is administered intravenously.

Financial Factors

This technology is commissioned by NHS England.

Dostarlimab with platinum-based chemotherapy will be funded by the cancer drugs fund while it is in managed access. More evidence on dostarlimab with platinum-based chemotherapy is being collected until the final results of the RUBY-1 trial are available. After this, NICE will decide whether or not to recommend it for use on the NHS and update the guidance.

NICE estimate that in Devon, 11 people will be eligible for second line treatment.

Highly Specialised Technology Guidance (HSTs)

None published this month.

NICE Guidelines (NGs)

Twin and triplet pregnancy NG137 (UPDATE)

This guideline covers care for pregnant women and pregnant people with a twin or triplet pregnancy in addition to routine care during pregnancy and labour. It aims to reduce the risk of complications and improve outcomes.

It should be read in conjunction with NICE's guidelines on antenatal care (**NG201**), intrapartum care (**NG235**) and fetal monitoring (**NG229**).

April 2024: NICE reviewed the evidence and made new and updated recommendations, and a recommendation for research, on interventions to prevent spontaneous preterm birth and progesterone for preventing spontaneous preterm birth in twin and triplet pregnancy.

Endometriosis: diagnosis and management NG73 (UPDATE)

This guideline covers diagnosing and managing endometriosis. It aims to raise awareness of the symptoms of endometriosis, and to provide clear advice on what action to take when women and people with signs and symptoms first present in healthcare settings. It also provides advice on the range of treatments available.

April 2024: NICE have reviewed the evidence and updated some recommendations and made a recommendation for research, on treatment of endometriosis when fertility is a priority. NICE have also amended the heading 'Surgical management when fertility is a priority' to 'Management if fertility is a priority' to recognise that this section also covers non-surgical options.

NICE Rapid COVID-19 Guidelines

None published this month.

Public Health Guidelines

None published this month.

Antimicrobial Prescribing Guidelines

None published this month.

Social Care Guidelines

None published this month.

Interventional Procedures Guidance (IPGs)

Lymphovenous anastomosis during axillary or inguinal node dissection for preventing secondary lymphoedema IPG785

Recommendations

Breast Cancer

Lymphovenous anastomosis during axillary dissection for preventing secondary lymphoedema in adults with breast cancer can be used in the NHS while more evidence is generated. It can only be used with **special arrangements** for clinical governance, consent, and audit or research.

Clinicians wanting to do lymphovenous anastomosis during axillary node dissection for preventing secondary lymphoedema in people with breast cancer should:

- Inform the clinical governance leads in their healthcare organisation.
- Ensure that people (and their families and carers as appropriate) understand the procedure's safety and efficacy, and any uncertainties about these.
- Take account of NICE's advice on shared decision making, including NICE's information for the public.
- Audit and review clinical outcomes of everyone having the procedure. The main efficacy and safety outcomes identified in this guidance can be entered into NICE's interventional procedure outcomes audit tool (for use at local discretion).
- Discuss the outcomes of the procedure during their annual appraisal to reflect, learn and improve.

Healthcare organisations should:

- Ensure systems are in place that support clinicians to collect and report data on outcomes and safety for everyone having this procedure.
- Regularly review data on outcomes and safety for this procedure.

Patient selection should be done by a multidisciplinary team experienced in managing the condition.

This procedure should only be done by a multidisciplinary team experienced in it, including a surgeon with specific training in microvascular surgery.

Other cancers

More research is needed on lymphovenous anastomosis during axillary or inguinal node dissection for preventing secondary lymphoedema for other cancers in adults.

This procedure should only be done as **part of a formal research study**, and a research ethics committee needs to have approved its use.

More research

More research is needed on:

- patient selection
- quality of life
- longer-term outcomes for lymphoedema incidence in different conditions
- limb volume
- safety outcomes (including survival and metastatic cancer).

The Condition

Lymphoedema is the build-up of lymph fluid in a limb, causing swelling of that limb. It is a common complication after treatments for various cancers and can be chronic and debilitating. The condition can severely damage the skin and cause aching in or difficulty moving the affected limb. There can also be recurrent skin infections, needing frequent antibiotic use and sometimes hospitalisation.

There are no curative treatments but there are various treatments to help control the symptoms of lymphoedema. They aim to reduce swelling and infection while improving lymphatic flow in the body, and include:

- decongestive lymphatic therapy, which comprises compression garments, manual lymphatic draining, skin care, exercise and massage done with specialist help or alone by the person with lymphoedema
- the 2 surgical techniques, liposuction and lymphovenous anastomosis.

The Procedure

This version of lymphovenous anastomosis is done during axillary or inguinal node dissection to reduce the risk of lymphoedema developing after surgery. This procedure, also known as LYMPHA (lymphatic microsurgical preventive healing approach), involves creating a bypass from the transected lymphatics to nearby veins. Before the node dissection, a blue dye is injected to map the lymphatic circulation from the arm or thigh. During the node dissection, the surgical team inserts the cut lymphatic vessels into a small branch of the axillary or saphenous veins with the aim of restoring normal lymph flow.

The standard LYMPHA technique is done by surgeons with microvascular experience, using an operating microscope and, typically, 9-0 to 12-0 sutures.

There is also a simplified technique known as S-LYMPHA, which can be done by surgeons without microsurgical training, without an operating microscope and using 7-0 sutures.

Epidermal radiotherapy using rhenium-188 paste for non-melanoma skin cancer IPG784

Recommendations

More research is needed on epidermal radiotherapy using rhenium-188 paste for non-melanoma skin cancer.

This procedure should only be done as part of a **formal research study** and a research ethics committee needs to have approved its use.

More research is needed on:

- details of patient selection
- tumour histology
- the site and size of the tumour
- the dose and number of treatments
- the treatment margin around the tumour
- remission status
- patient-reported outcome measures, including cosmetic outcomes

- safety outcomes.

The Condition

Non-melanoma skin cancer is the most common type of cancer. It affects the cells in the top layers of the skin. The most common types of non-melanoma skin cancer are basal cell carcinoma and squamous cell carcinoma. The main symptom is the appearance of lesions (lumps or discoloured patches) on the skin. The lesions are mostly found on skin that is regularly exposed to the sun.

Standard care depends on the initial presentation of non-melanoma skin cancer, such as the type, size and location of the tumour. Surgery is the main treatment. Other treatment options include chemotherapy cream, immunotherapy creams, cryotherapy, brachytherapy, external beam radiotherapy and photodynamic therapy.

The Procedure

The procedure is done without the need for anaesthesia or inpatient admission. It uses a beta-emitter radioisotope, rhenium-188, which can penetrate human tissue up to 3 mm deep. Rhenium-188 is bound to a matrix to form a paste.

During the procedure, the area to be treated is protected from direct contact with the paste by a cream or sterile transparent foil. The paste is then applied over the area of the tumour using a safety margin, using a specially designed applicator. The treatment time is typically 30 to 180 minutes and is calculated based on the target dose of radioactivity and the depth and size of the area to be treated. The paste dries out during the treatment time and turns into a flexible film. The film is removed when the treatment is over. The dead cancer cells are gradually replaced with new healthy cells.

Medical Technologies Guidance (MTGs)

GaitSmart rehabilitation exercise programme for gait and mobility issues MTG78

Recommendations

Adults at risk of falls

For adults at risk of falls, GaitSmart rehabilitation exercise programme **can be used** to treat gait and mobility issues in the NHS while more evidence is generated.

Adults having hip or knee replacements

For adults having hip or knee replacements, **more research** is needed on GaitSmart rehabilitation exercise programme to treat gait and mobility issues before or after surgery.

Access to the technology for adults having hip or knee replacements should be through company, research or non-core NHS funding and clinical or financial risks should be appropriately managed.

Evidence generation and research

Further evidence is needed on the clinical effectiveness of GaitSmart, including:

- studies with larger populations
- comparative studies
- adherence to the rehabilitation exercise programme
- adverse effects.

The Technology

People aged 65 and over have the highest risk of falling. 30% of people older than 65 and 50% of people older than 80, fall at least once a week. Falling can be distressing and cause pain, injury, and loss of mobility. People can lose confidence and, in some cases, lose their independence because of a fall.

Knee or hip replacement refers to a surgical procedure where a person has their knee joint, or hip joint, replaced (wholly or partially) with an artificial one. The NHS website states that a knee or hip replacement is needed when the joint is worn or damaged so that a person's mobility is reduced and they are in pain even when resting.

Current management options for people with gait and mobility issues varies depending on the underlying cause and severity of the symptoms.

When seeing a health care professional, people over the age of 65 are asked about any falls within the last year, as recommended in **CG161**. The guideline states that older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance are offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service.

Referral for surgery should be considered for people who experience knee or hip joint symptoms that have a substantial impact on their quality of life and have been offered or have symptoms that are not resolved by the core (non-surgical) treatment options.

GaitSmart rehabilitation exercise programme is intended for people who are ambulatory or partially ambulatory and have gait and mobility issues. It comprises digital gait assessment and personalised rehabilitation exercises. GaitSmart is a CE marked class 1 medical device that uses sensor-based digital technology to monitor limb movement.

Objective measurements are taken while the person is walking to identify any problems with gait. Information from the sensors is automatically processed to produce a colour-coded report that helps the person and healthcare professional to understand any gait issues and the severity. The test takes 10 minutes to complete and can be done by a healthcare assistant in a variety of settings.

The gait assessment produced by GaitSmart is used with an integrated app for healthcare professionals, vGym. This produces a personalised rehabilitation programme consisting of 6 exercises to help improve mobility. The report includes photos and descriptions of each exercise, and advice. It can be printed off and used without patients needing access to a digital device. They can also view the report on a web browser if preferred.

Once allocated to the GaitSmart programme, each person should have a total of 4 gait assessments, done by a healthcare assistant, every 3 to 6 weeks. Each gait assessment identifies any changes in gait and mobility and alters the exercises accordingly.

Financial Factors

These technologies are commissioned by ICBs.

Reviewed evidence and clinical expert opinion suggests that implementing the guidance may:

- widen access to services due to the mobile nature of the technology, that is gait assessments could be done in appropriate local facilities, promoting collaboration with the voluntary, charitable and third sector providers
- allow a trained healthcare assistant to carry out GaitSmart sessions; in standard care these sessions are normally done by a more senior clinical person, usually a physiotherapist
- help fill a treatment gap for people who may not be able to access gait rehabilitation services
- provide an automated personalised exercise programme matched to individual gait results to improve gait
- increase motivation and concordance with exercise due to the provision of colour-coded individual reports at each assessment
- help individuals to understand their gait parameters and know whether they have issues that can affect balance, strength or stability.

These benefits may also provide some savings to offset some of the potential costs that may result from using GaitSmart.

Kurin Lock for blood culture collection MTG77

Recommendations

Kurin Lock **can be used** in the NHS to reduce contamination in blood culture collection in emergency departments with high blood culture contamination rates while more evidence is generated.

Evidence should be generated on:

- the resource impact of blood culture test results, including data on length of hospital stay, antibiotic use, further microbiological investigations and medical interventions
- staff adherence to blood culture collection methods
- baseline blood culture contamination rates, and any change in these rates from using Kurin Lock.

The Technology

People who are suspected to have a bloodstream infection or sepsis have a blood sample collected. The sample is sent to a laboratory for culturing to detect and potentially identify the infection. Current management involves cleaning the injection site with antiseptic, inserting the needle and collecting blood directly into blood culture collection bottles. Measures such as appropriate skin and bottle preparation, taking cultures from peripheral venepuncture instead of catheters and training, can minimise contamination risk. At least 40 ml of blood should be cultured for optimum detection of bloodstream infections. This requires at least 2 sets of blood culture samples to be taken within a few hours of each other.

In clinical practice, once the infection-causing pathogen is identified, the initial antibiotic therapy may be changed to target the identified pathogen. This allows for more appropriate and tailored treatment. If the pathogen is considered to be a contaminant, then antibiotic treatment will be stopped.

Kurin Lock is a CE-marked class IIa medical device, intended for use in collecting blood samples to check for the presence of infections. The Kurin Lock device consists of a needle, a flash chamber to collect, isolate and display the first 0.15 ml of blood drawn, and a tube to collect the remaining blood sample, which goes on to be cultured and analysed.

Kurin Lock is intended for use in secondary care, for people who have blood culture samples taken when bloodstream infections are suspected. This includes in emergency departments, intensive care units and other general inpatient wards. Specific subgroups who may benefit from Kurin Lock include populations in which taking blood samples may be more difficult, and so the risk of contamination is higher. For example, taking blood samples from children or from intravenous drug users. Other specific subgroups who may benefit from Kurin Lock include those in which organisms that would normally be considered contaminants may be a causative pathogen. For example, people with implanted cardiac devices or prosthetic valves.

Financial Factors

This technology is commissioned by ICBs.

Clinical trial evidence suggests that Kurin Lock is a safe and effective way of reducing blood culture contamination rates, compared with standard blood culture collection. It is not clear how it affects other outcomes, like length of hospital stay and antibiotic use, because the clinical trials did not formally record these outcomes.

The economic modelling is also uncertain, and it is unclear if Kurin Lock is cost incurring or cost saving. Kurin Lock costs much more than standard blood culture collection. So, it is more likely that Kurin Lock is cost saving when it is used in emergency departments with high rates of blood culture contamination.

Evidence generation would help address uncertainties in the cost-effectiveness evidence. Therefore, Kurin Lock is recommended for use in emergency departments with high blood culture contamination rates while evidence is generated.

Diagnostics Guidance (DGs)

None published this month.

Health Technology Evaluations (HTE)

Digital technologies to deliver pulmonary rehabilitation programmes for adults with COPD: early value assessment HTE18

Recommendations

Can be used in the NHS while more evidence is generated

myCOPD **can be used** in the NHS while more evidence is generated, to deliver pulmonary rehabilitation programmes for adults with chronic obstructive pulmonary disease (COPD) who cannot have or do not want face-to-face pulmonary rehabilitation.

The company (my mhealth) must confirm that agreements are in place to generate the evidence (as outlined in NICE's evidence generation plan) and contact NICE annually to confirm that evidence is being generated and analysed as planned. NICE may withdraw the guidance if these conditions are not met.

At the end of the evidence generation period (3 years), the company should submit the evidence to NICE in a form that can be used for decision making. NICE will review the evidence and assess if the technology can be routinely adopted in the NHS.

Can only be used in research

More research is needed on 5 digital technologies to deliver pulmonary rehabilitation programmes for adults with COPD who cannot have or do not want face-to-face pulmonary rehabilitation. The technologies are:

- Active+me REMOTE
- Clinitouch
- Kaia Health COPD
- Rehab Guru, and
- Wellinks.

Access to the technologies in section above should be through company, research, or non-core NHS funding, and clinical and financial risks should be appropriately managed.

Evidence generation and more research

Evidence generation and more research is needed:

- on how well the digital technologies work compared with:
    - pulmonary rehabilitation following the British Thoracic Society's guideline on face-to-face pulmonary rehabilitation programmes (PDF)
    - not having or waiting to have a face-to-face programme
- measuring the following outcomes:
    - health-related quality of life and exercise capacity (using validated measures)
    - resource use, including technology costs, exacerbation-related costs, and implementation costs
    - uptake rates
    - intervention adherence rates
    - intervention completion rates
    - patient preference and experience
    - adverse events
    - exacerbation rate
    - hospitalisation from exacerbation

    - long-term effect up to 12 months
- on where the technologies will be used in the care pathway
- reporting outcomes in the following subgroups:
    - people living in urban areas compared with people living in rural areas
    - people with a new COPD diagnosis compared with those with an existing diagnosis
    - people who depend on supplemental oxygen to manage COPD
    - people recently discharged from hospital after an exacerbation.

    The evidence generation plan gives further information on the prioritised evidence gaps and outcomes, ongoing studies and potential real-world data sources for myCOPD. It includes how the evidence gaps could be resolved through real-world evidence studies.

The Technology

COPD is a long-term and progressive respiratory condition that causes breathlessness, a persistent chesty cough, persistent wheezing and frequent chest infections. COPD includes chronic bronchitis and emphysema. COPD mainly affects older adults who smoke and many people do not realise they have it. Breathing problems had with COPD tend to get worse over time and can limit a person's ability to do daily activities. Treatment can help keep the condition under control and includes stopping smoking, using inhalers and tablets, pulmonary rehabilitation, and surgery.

COPD exacerbations are the second most common cause of emergency hospital admissions~~,~~ Exacerbations requiring hospital treatment are associated with poorer prognosis and an increased risk of death.

Pulmonary rehabilitation is an exercise and education programme for people with lung disease, including COPD, who experience breathlessness. Evidence suggests that 90% of patients who complete a pulmonary rehabilitation programme experience increased exercise capacity and improved quality of life. However, it is currently only offered to 13% of eligible COPD patients, with a focus on those with more severe COPD. Clinical experts state that limitations in workforce and service funding restrict the ability of the NHS to provide pulmonary rehabilitation to all patients who may benefit.

Digital technologies to deliver pulmonary rehabilitation for COPD provide parts of face-to-face pulmonary rehabilitation. Pulmonary rehabilitation programmes should include an in-person assessment before starting and after completion, physical training, disease education and nutritional, psychological and behavioural interventions. Digital technologies to deliver pulmonary rehabilitation programmes would be offered as an option to adults with COPD who are eligible for a pulmonary rehabilitation course but cannot, or do not want to, attend face-to-face sessions. They would not replace face-to-face pulmonary rehabilitation programmes.

Financial Factors

This technology is commissioned by ICBs.

Based on the economic assessment, digital technologies are likely to be either similar or less effective compared to face-to-face exercise sessions in pulmonary rehabilitation.

Clinical evidence suggests that myCOPD may improve exercise capacity and symptoms of COPD. There are no particular safety concerns with using a digital technology to deliver pulmonary rehabilitation. The technology may address an unmet need for people with COPD who are eligible for pulmonary rehabilitation but who are not offered it. The technology can be used to complement standard care face-to-face pulmonary rehabilitation programmes. People using a digital technology will require fewer face-to-face exercise sessions as they can carry out exercise sessions at home. myCOPD also supports self-management by providing educational sessions, self- care tools and educational resources for people with all stages of COPD.

Digital pulmonary rehabilitation could be cheaper to provide than standard care face-to-face pulmonary rehabilitation when comparing the license costs of digital technologies and staff time, with the staff time for delivering all the components of pulmonary rehabilitation programmes face-to-face. However, it is uncertain what staff time is needed to deliver face-to-face exercise sessions as this will depend on the service configuration.

NICE estimate that in Devon, 19,985 people will be eligible for pulmonary rehabilitation at year five.

NICE Quality Standards

None published this month.

Current NICE Consultations

Title/link	End date of consultation
Quality Standards Interim Process Guide	15/05/2024
Idebenone for treating visual impairment in Leber's hereditary optic neuropathy in people 12 years and over [ID547]	16/05/2024
Single-step scaffold insertion for repairing symptomatic chondral knee defects	22/05/2024
Blinatumomab with chemotherapy for consolidation treatment of Philadelphia-chromosome-negative CD19-positive B-precursor acute lymphoblastic leukaemia with no measurable residual disease ID6405	23/05/2024