NHS
Devon
Clinical Commissioning Group

NICE Update Bulletin: January 2020

Hyperlinks to the relevant NICE web page are included below.

Technology Appraisals (TAs)

Osimertinib for untreated EGFR mutation-positive non-small-cell lung cancer TA621

Recommendations

Osimertinib is **not recommended**, within its marketing authorisation, for untreated locally advanced or metastatic epidermal growth factor receptor (EGFR) mutation-positive non-small-cell lung cancer (NSCLC) in adults.

This recommendation is not intended to affect treatment with osimertinib 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

Osimertinib is indicated for the first-line treatment of adult patients with locally advanced or metastatic non-small cell lung cancer with activating epidermal growth factor receptor (EGFR) mutations.

The dosage is 80 mg taken orally once daily until disease progression or unacceptable toxicity. EGFR mutation status in tumour or plasma specimens should be determined using a validated test method. Dosing interruption with or without dose reduction may be needed based on individual safety and tolerability. If dose reduction is necessary, then the dose should be reduced to 40 mg once daily.

Financial factors

This technology is commissioned by NHS England.

Osimertinib does not meet NICE's criteria to be considered a life-extending treatment at the end of life. The most plausible cost-effectiveness estimates are above what NICE normally considers an acceptable use of NHS resources. Osimertinib is therefore not recommended.

Although some of the clinical uncertainty could be addressed through collecting further data from the clinical trial, osimertinib does not meet NICE's criteria to be included in the Cancer Drugs Fund because it does not have the potential to be cost effective at the price offered.

Olaparib for maintenance treatment of relapsed platinum-sensitive ovarian, fallopian tube or peritoneal cancer TA620

Recommendations

Olaparib is **recommended** as an option for the maintenance treatment of relapsed, platinum-sensitive, high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer in adults whose disease has responded to platinum-based chemotherapy only if:

- they have a BRCA1 or BRCA2 mutation
- they have had 3 or more courses of platinum-based chemotherapy and
- the company provides olaparib according to the commercial arrangement.

Olaparib is **recommended for use within the Cancer Drugs Fund** as an option for the maintenance treatment of relapsed, platinum-sensitive, high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer in adults whose disease has responded to platinum-based chemotherapy only if:

- they have a BRCA1 or BRCA2 mutation
- they have had 2 courses of platinum-based chemotherapy and
- the conditions in the managed access agreement for olaparib are followed.

These recommendations are not intended to affect treatment with olaparib that was started in the NHS before this guidance was published. People having treatment outside these recommendations 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

Olaparib as tablets is indicated as monotherapy for the maintenance treatment of adult patients with platinum-sensitive relapsed high-grade epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in response (complete or partial) to platinum-based chemotherapy.

Olaparib is taken orally. It is currently available both in a tablet and a capsule formulation. However, the capsule formulation is only licensed for people with a BRCA mutation and platinum-sensitive ovarian cancer and will be phased out when no longer needed by patients. Therefore, only the tablets are covered by this appraisal. The dosage of olaparib tablets is 300 mg (2×150-mg tablets) taken twice daily (600 mg per day).

Financial factors

This technology is commissioned by NHS England.

For people with a BRCA mutation who have had 3 or more courses of platinum-based chemotherapy, olaparib meets NICE's end-of-life criteria. It is cost effective for this group of people and is therefore recommended for routine use in the NHS.

For people with a BRCA mutation who have had 2 courses of platinum-based chemotherapy, olaparib does not meet NICE's end-of-life criteria. The cost-effectiveness estimates are uncertain because overall survival data from the most

relevant clinical trial are not yet available. Olaparib has the potential to be cost effective if further data confirm the overall survival benefit estimated using the company's alternative model. Olaparib is therefore recommended for use within the Cancer Drugs Fund, for people with a BRCA mutation who have had 2 courses of platinum-based chemotherapy, while more data are collected.

There is a simple discount patient access scheme and a commercial access agreement for olaparib. These form part of the managed access agreement when olaparib is used in the Cancer Drugs Fund.

Palbociclib with fulvestrant for treating hormone receptor-positive, HER2-negative, advanced breast cancer TA619

Recommendations

Palbociclib with fulvestrant is **recommended for use within the Cancer Drugs Fund** as an option for treating hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer in people who have had previous endocrine therapy only if:

- exemestane plus everolimus is the most appropriate alternative to a cyclin-dependent kinase 4 and 6 (CDK 4/6) inhibitor and
- the conditions in the managed access agreement for palbociclib with fulvestrant are followed.

This recommendation is not intended to affect treatment with palbociclib with fulvestrant 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

Palbociclib is indicated for the treatment of hormone receptor-positive, human epidermal growth factor receptor 2-negative locally advanced or metastatic breast cancer in combination with an aromatase inhibitor or in combination with fulvestrant in women who have received prior endocrine therapy. In pre- or perimenopausal women, the endocrine therapy should be combined with a luteinising hormone-releasing hormone agonist.

The recommended dose is 125 mg, taken orally, once daily for 21 consecutive days, followed by 7 days off treatment (28-day cycle). Treatment should be continued as long as the patient is having clinical benefit from therapy or until unacceptable toxicity happens.

Financial factors

This technology is commissioned by NHS England.

NICE estimates that up to 3,300 people per year with hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer in people who have had previous endocrine therapy are eligible for treatment with palbociclib with fulvestrant. This is a further treatment option for this population.

Palbociclib with fulvestrant will be available to the NHS in line with the managed access agreement with NHS England. As part of this, NHS England and Pfizer have a commercial access agreement that makes palbociclib available to the NHS at a reduced cost. The financial terms of the agreement are commercial in confidence.

The resource impact of palbociclib and fulvestrant will be covered by the Cancer Drugs Fund budget. The guidance will be reviewed by the date the managed access agreement expires (January 2022) or when the results of the managed access agreement data collection are available, whichever is sooner. The aim of the review is to decide whether or not the drug can be recommended for routine use.

Atezolizumab with carboplatin and nab-paclitaxel for untreated advanced non-squamous non-small-cell lung cancer TA618 *(terminated appraisal)*

NICE is **unable to make a recommendation** on atezolizumab with carboplatin and nab-paclitaxel for untreated advanced non-squamous non-small-cell lung cancer, because Roche did not provide an evidence submission. NICE will review this decision if the company decides to make a submission.

Lusutrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure TA617

Recommendations

Lusutrombopag is **recommended**, within its marketing authorisation, as an option for treating severe thrombocytopenia (that is, a platelet count of below 50,000 platelets per microlitre of blood) in adults with chronic liver disease having planned invasive procedures.

The scope for this technology appraisal also includes avatrombopag; however NICE cannot release any recommendations on avatrombopag until it has an agreed list price in the UK.

The technology

People with chronic liver disease often have low blood platelet levels. This means that they are more likely to bleed during invasive medical procedures, including surgery. Currently, they have a platelet transfusion before invasive procedures to help reduce their chances of bleeding.

Avatrombopag and lusutrombopag are oral therapies that raise platelet levels, the aim being to reduce (but not eliminate) the chances of a patient needing a platelet transfusion. Platelet transfusions rely on donors and are given intravenously, so the possibility of replacing them with an oral treatment is an improvement.

In addition, platelets are a limited resource and can only be stored for a short time. This means that there can be problems getting them to people in time for their procedure, which can delay surgery. On the other hand, avatrombopag and lusutrombopag need to be taken more than a week before a procedure, so can be used only for planned procedures.

Clinical trial evidence shows that fewer people need a platelet transfusion if they have avatrombopag or lusutrombopag rather than a placebo treatment. But whether the drugs improve survival compared with platelet transfusions has not been measured. There is also no clinical evidence that either drug is better than the other.

The economic modelling does not fully account for the benefits for patients and service delivery when using avatrombopag and lusutrombopag. If these are considered, using lusutrombopag would likely save the NHS money. So, lusutrombopag can be recommended for treating thrombocytopenia in people with chronic liver disease who need planned invasive procedures. It is not possible for NICE to make a recommendation for avatrombopag because the drug does not have a UK price.

Financial factors

This technology is commissioned by CCGs.

NICE does not expect this guidance to have a significant impact on resources; the technology is a further treatment option and due to this the overall incremental cost of treatment is not deemed to be significant.

The addition of lusutrombopag in the treatment pathway may help reduce the need for platelet transfusions. It may also help increase the time in which procedures can be scheduled and reduce hospital stays.

Highly specialised technology guidance (HSTs)

None published this month.

NICE Guidelines (NGs)

Colorectal cancer NG151

This guideline covers managing colorectal (bowel) cancer in people aged 18 and over. It aims to improve quality of life and survival for adults with colorectal cancer through management of local disease and management of secondary tumours (metastatic disease).

This guideline includes recommendations on:

- prevention of colorectal cancer in people with Lynch syndrome
- information for people with colorectal cancer
- management of local disease
- molecular biomarkers to guide systemic anti-cancer therapy
- management of metastatic disease
- ongoing care and support

Supporting adult carers NG150

This guideline covers support for adults (aged 18 and over) who provide unpaid care for anyone aged 16 or over with health or social care needs. It aims to improve the lives of carers by helping health and social care practitioners identify people who are caring for someone and give them the right information and support. It covers carers' assessments, practical, emotional and social support and training, and support for carers providing end of life care.

This guideline covers general principles that apply to all adult carers. Recommendations about supporting carers of people with specific health needs can be found in NICE guidance on those conditions.

The guideline should be read together with the Care and support statutory guidance under the Care Act 2014 and the Children and Families Act 2014.

This guideline includes recommendations on:

- information and support for carers
- identifying carers and assessing their needs
- helping carers stay in, enter or return to work, education and training
- social and community support for carers
- training to provide care and support
- psychological and emotional support for carers
- support during changes to the caring role and during end of life care

Public Health Guidelines

Indoor air quality at home NG149

This guideline covers indoor air quality in residential buildings. It aims to raise awareness of the importance of good air quality in people's homes and how to achieve this.

This guideline includes recommendations on:

- prioritising indoor air quality in local strategy or plans
- housing assessment referrals
- raising awareness of poor indoor air quality in the home and advice for the general public
- advice for people with pre-existing health conditions and pregnant women
- using standards to improve indoor air quality
- ensuring architects and designers take account of indoor air quality
- ensuring builders, contractors and developers comply with building standards
- ensuring rental properties comply with regulations

Antimicrobial prescribing guidelines

None published this month.

Social Care guidelines

None published this month.

Interventional Procedures Guidance (IPGs)

Open prenatal repair for open neural tube defects in the fetus IPG668

Recommendations

Evidence on the efficacy of open prenatal repair of open neural tube defects in the fetus is adequate in quantity and quality. However, evidence on its safety shows serious but well recognised safety concerns for the mother and fetus. Therefore, this procedure should only be used with **special arrangements** for clinical governance, consent, and audit or research.

Clinicians wishing to do open prenatal repair of open neural tube defects in the fetus should:

- Inform the clinical governance leads in their NHS trusts.
- Give parents clear written information to support shared decision making, including NICE's information for the public.
- Ensure that parents understand the procedure's safety and efficacy, as well as any uncertainties about these.
- Audit and review clinical outcomes of everyone having the procedure. NICE has identified relevant audit criteria and has developed an audit tool (which is for use at local discretion).

The procedure is technically challenging and should only be done in specialised centres, and only by clinicians and teams with specific training and experience in open prenatal repair.

Patient selection should only be done by a multidisciplinary team, which should include a consultant in fetal medicine, an obstetric surgeon, a paediatric neurosurgeon, a radiologist with experience in fetal imaging and an anaesthetist.

Further research should report details of risks to the mother (including her subsequent pregnancies), risks to the fetus (including the need for further surgery) and long-term disability after birth.

The condition

Neural tube defects happen because the neural tube does not fuse during early embryonic development. Open neural tube defects are those in which the affected region of the neural tube is exposed on the body's surface. The most common neural tube defect is spina bifida, where the defect is in the spine. Myelomeningocele (open spina bifida) is the most severe type of spina bifida, in which the baby's spinal canal remains open along several vertebrae in the back. The spinal cord and protective membranes around it push out and form a sac, which is exposed on the baby's back. Children born with myelomeningocele may experience motor neurological deficits including muscle weakness and paralysis of the lower limbs, sensory deficit, bowel, bladder and sexual dysfunctions, and learning difficulties. The condition can be associated with Chiari II malformation (hindbrain herniation) and hydrocephalus.

Conventional treatment for myelomeningocele (open spina bifida) is immediate surgical repair of the defect within days of birth to prevent further damage to nervous tissue and reduce the risk of central nervous system infection.

The immediate management may also include ventricular-peritoneal shunt placement to relieve hydrocephalus. The condition can also be treated prenatally with the aim of decreasing morbidity in the child.

The procedure

Open prenatal repair for open neural tube defects is typically done before 26 weeks of pregnancy. Using general anaesthesia, a low transverse laparotomy incision is done and the gravid uterus is exposed and exteriorised. The fetus and placenta are visualised by ultrasound, and the fetus is manually positioned to allow a uterine incision (hysterotomy) over the centre of the myelomeningocele sac. The hysterotomy location is either anterior, fundal or posterior depending on the location of the placenta. The hysterotomy is made large enough to allow the neural tissue in the meningomyelocele to be dissected from surrounding tissue so that it can drop into the spinal canal. The defect is then closed. If there is insufficient dura or skin for closure, occasionally a biocellulose and dermal regeneration patch substitute may be used for repair. The uterine incision is closed and a sodium lactate solution with antibiotics is added to the uterus until the amniotic fluid index is normal. The maternal abdominal wound is then closed.

Fetoscopic prenatal repair for open neural tube defects in the fetus IPG667

Recommendations

Evidence on the safety and efficacy of fetoscopic prenatal repair of open neural tube defects in the fetus is inadequate in quantity and quality. Therefore, this procedure should only be used in the **context of research**. This could be in the form of randomised controlled trials or published registry data.

The procedure is technically challenging and should only be done in specialised centres, and only by clinicians and teams with specific training and experience in fetoscopic prenatal repair.

Patient selection should only be done by a multidisciplinary team, which should include a consultant in fetal medicine, an obstetric surgeon, a paediatric neurosurgeon, a radiologist with experience in fetal imaging and an anaesthetist.

Further research should report details of risks to the mother (including her subsequent pregnancies), risks to the fetus (including the need for further surgery), and long-term disability after birth.

The condition

Neural tube defects happen because the neural tube does not fuse during early embryonic development. Open neural tube defects are those in which the affected region of the neural tube is exposed on the body's surface. The most common neural tube defect is spina bifida where the defect is in the spine. Myelomeningocele (open spina bifida) is the most severe type of spina bifida, in which the baby's spinal canal remains open along several vertebrae in the back. The spinal cord and protective membranes around it push out and form a sac which is exposed on the baby's back. Children born with myelomeningocele may experience motor neurological deficits including muscle weakness and paralysis of the lower limbs, sensory deficit, bowel, bladder and sexual dysfunctions and learning difficulties. The condition can be associated with Chiari II malformation (hindbrain herniation) and hydrocephalus.

Conventional treatment for myelomeningocele (open spina bifida) is immediate surgical repair of the defect within days of birth to prevent further damage to nervous tissue and reduce the risk of central nervous system infection. The immediate management may also include ventricular-peritoneal shunt placement to relieve hydrocephalus. The condition can also be treated prenatally with the aim of decreasing morbidity in the child.

The procedure

Fetoscopic prenatal repair is typically done before 26 weeks of pregnancy. It is done using general anaesthesia and with partial CO_2 insufflation of the uterine cavity. Under ultrasound guidance an endoscope is introduced through a port followed by the introduction of additional ports to allow the passage of instruments. Once the fetus is positioned adequately, the skin around the fetal neural placode/elements is dissected. Occasionally a biocellulose patch may be placed between the neural elements (defect) and the skin. Myofascial flaps are created and sutured on top of the biocellulose patch. The skin is then sutured using interrupted stitches over the patch or, for a large defect, a dermal regeneration patch substitute can be used for repair.

Reducing the risk of transmission of Creutzfeldt–Jakob disease (CJD) from surgical instruments used for interventional procedures on high-risk tissues IPG666

This guidance replaces NICE interventional procedures guidance on patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures (IPG196).

Recommendations

Decontamination

All surgical instruments that come into contact with high-risk tissues during an interventional procedure must be kept moist and separated from other instruments until they are cleaned, and then disinfected and sterilised (decontaminated). This improves the efficacy of the decontamination process and is highly cost effective.

Set integrity and tracking

Surgical instruments that come into contact with high-risk tissues must not be moved from one set to another and must remain within their individual sets. Maintaining set integrity reduces the risks associated with instrument migration (including infection) and makes it easier to trace instruments back to the patients they were used on.

Supplementary instruments

Supplementary instruments that come into contact with high-risk tissues must remain within the individual set to which they have been introduced. Supplementary instruments are those that are not part of a specific instrument set. If supplementary instruments are used with different sets, this would compromise set traceability and increases the risks associated with instrument migration.

Neuroendoscopy

Rigid neuroendoscopes (rather than flexible neuroendoscopes) should be used if possible. They should be of a type that can be steam sterilised and must be thoroughly cleaned and steam sterilised after each use.

Single-use instruments

The evidence on cost effectiveness does not support using sets of single-use instruments to reduce the risk of Creutzfeldt–Jakob disease (CJD) transmission.

Systems specifically for people born after 1996

The evidence on cost effectiveness does not support introducing systems to maintain separate sets of neuroendoscopes and reusable surgical instruments for use on high-risk tissues for people born after 1996.

Removing the requirement to use different instruments on high-risk tissues for people born after 1996 would not markedly increase the risk of surgical transmission of CJD.

Other relevant guidance

This guidance should be used with:

- the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathies subgroup's previous guidance on Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection
- the Department of Health and Social Care's Health Technical Memorandum 01-01: decontamination of surgical instruments (2016) and corresponding guidance in the devolved administrations' areas.

Further research

NICE may update this guidance after 3 years or sooner if important new information becomes available, including evidence on:

- the epidemiology of CJD, including data on the prevalence of CJD and its infectivity in the UK population
- the transmission of CJD by surgical instruments, including cases of CJD in which surgery is a possible route of transmission
- the cost effectiveness of single-use instruments for use in interventional procedures on high-risk tissues
- commercially available decontamination methods that are safe and cost effective against prions
- the systems for, and cost effectiveness of, maintaining set integrity and traceability of instruments.

The condition

Creutzfeldt–Jakob disease (CJD) is a progressive, fatal neurological disease affecting the brain. CJD belongs to a wider group of neurodegenerative disorders known as transmissible spongiform encephalopathies (TSEs) that affect both humans and animals. People with CJD typically present with rapidly progressive dementia, usually accompanied by myoclonus and cerebellar ataxia. Most people die within 4 months of disease onset, in a mute and immobile state.

It is caused by pathological accumulation of a transmissible form of protein called a prion. The highest levels of prions are found in tissues such as the brain, pituitary gland, spinal cord and parts of the eye. Prions cannot be inactivated or removed by normal hospital cleaning and sterilisation methods. So there is a risk that surgical instruments carrying prions could spread CJD from one patient to another, even when the instruments have been properly washed and disinfected.

Medical Technologies Guidance (MTGs)

Virtual Touch Quantification to diagnose and monitor liver fibrosis in chronic hepatitis B and C MTG27 (update)

In January 2020, NICE updated this guidance to reflect new pooled estimates for the sensitivity and specificity of VTq for hepatitis C. For the guidance review it was noted that the differences between the updated pooled estimates compared with the pooled estimates used in the original model are minor.

Recommendations

The case for adopting Virtual Touch Quantification (VTq) software to diagnose and monitor liver fibrosis is **supported** by the evidence. VTq is as accurate as transient elastography in diagnosing and staging liver fibrosis, and may offer other benefits in terms of imaging the liver and sampling selected areas to assess fibrosis and identify associated pathologies. By avoiding liver biopsies, it may also benefit people whose liver fibrosis needs monitoring. Cost savings through adopting VTq will be greater in hospitals in which liver biopsy is the primary method for diagnosing and monitoring liver fibrosis.

VTq should be considered as an option for people with chronic hepatitis B or C who need assessment of liver fibrosis.

Cost modelling suggests that using VTq is cost saving compared with transient elastography and liver biopsy, whether or not a compatible Siemens ultrasound machine needs to be purchased. Compared with transient elastography, the estimated overall cost saving for VTq is around £53 per person. This saving assumes that 10% of the ultrasound machine capacity would be used for VTq measurements, leaving 90% to be applied to other uses. Compared with liver biopsy, the corresponding saving is around £434 per person.

The technology

The Virtual Touch Quantification (VTq) software application uses acoustic radiation force impulse (ARFI) imaging technology to measure the elasticity of liver tissue. VTq is used in combination with a Siemens Acuson S2000 or S3000 ultrasound platform. Liver tissue can be damaged by inflammation, causing high levels of collagen to be deposited in the liver cells (fibrosis), which become stiff. ARFI imaging involves generating a shear wave by applying an acoustic 'push pulse' lateral to the area of interest identified during a conventional ultrasound scan. The speed of the shear wave is proportional to the stiffness of the tissue.

The VTq investigation comprises multiple measurements and is both non-invasive and painless. The software generates a report which includes a statistical summary of the median and mean shear-wave velocities. The reliability of VTq measurements is usually confirmed by calculating the ratio of the interquartile range to median, which should be less than 0.30. VTq is indicated for adults or children needing assessment of liver fibrosis.

Diagnostics Guidance (DGs)

None published this month.

NICE Quality Standards

Cerebral palsy in adults QS191

This quality standard covers care and support for adults with cerebral palsy (aged 25 and over). It describes high-quality care in priority areas for improvement.

There is a separate NICE quality standard on cerebral palsy in children and young people.

Colorectal cancer QS20 (update)

This quality standard covers managing colorectal (bowel) cancer in adults (aged 18 and over). It includes managing local disease and secondary tumours (metastatic disease). It describes high-quality care in priority areas for improvement.

In January 2020, this quality standard was updated to reflect changes to the updated NICE guideline on colorectal cancer. Statements 1, 2, 3, 5 and 7 were removed because they are no longer in line with the NICE guideline. Statements 4 and 6 were amended to better reflect the updated guideline. For statement 4, 'risk' of recurrence was replaced with 'stage' and the measures were updated. For statement 6, the wording was changed to be clearer that the statement applies to people with metastatic colorectal cancer in the liver and that review is for suitability for local, rather than surgical, treatment only. New timescales for post-resection colonoscopy were also added to the measures for statement 8. Data sources, links and references were also updated throughout.

Flu vaccination: increasing uptake QS190

This quality standard covers increasing the uptake of flu vaccination among people who are eligible. It describes high-quality care in priority areas for improvement.

It does not cover uptake of flu vaccination in people aged 65 and over.

Rheumatoid arthritis in over 16s QS33 (update)

This quality standard covers assessing, diagnosing and managing rheumatoid arthritis in over 16s. It describes high-quality care in priority areas for improvement.

In January 2020, this quality standard was updated in response to an annual review, which identified changes in the areas for improvement for this topic.

Current NICE consultations

Title / link	End date of consultation
Deep brain stimulation for refractory epilepsy	04/02/2020
Transcranial magnetic stimulation for obsessive-compulsive disorder	04/02/2020
Treosulfan with fludarabine for malignant disease before allogeneic stem cell transplant [ID1508]	04/02/2020
Implantable cardiac monitors to detect atrial fibrillation after cryptogenic stroke	04/02/2020
Rehabilitation in adults with complex psychosis and related severe mental health conditions	05/02/2020
Pembrolizumab for untreated metastatic or unresectable recurrent squamous cell head and neck cancer [ID1140]	05/02/2020
Gilteritinib for treating relapsed or refractory acute myeloid leukaemia [ID1484]	05/02/2020
Larotrectinib for treating advanced solid tumours with TRK fusions [ID1299]	07/02/2020
Skin tumours including Melanoma: assessment and management	11/02/2020
Ustekinumab for treating moderately to severely active ulcerative colitis [ID1511]	11/02/2020
Supporting adult carers	13/02/2020
Community pharmacies: promoting health and wellbeing	14/02/2020
Liraglutide for managing overweight and obesity [ID740]	14/02/2020
Multiple sclerosis in adults: management	17/02/2020
Esketamine for treatment-resistant depression (ID1414)	18/02/2020
Lorlatinib for treating ALK-positive advanced non-small-cell lung cancer [ID1338]	18/02/2020
Vagus nerve stimulation for treatment-resistant depression	20/02/2020
Faltering growth	21/02/2020
Upadacitinib for treating moderate to severe rheumatoid arthritis [ID1400]	21/02/2020
Behaviour change: digital and mobile health interventions	06/03/2020