

## Minutes - Scottish Health Technologies Group Council

**Date** 16 December 2024 13:00-16:00

**Venue:** MS Teams

**Contact:** [his.shtg@nhs.scot](mailto:his.shtg@nhs.scot)

### Attendance

#### Council Members

1. **Neil Smart**, Council Chair, Consultant Anesthetist, NHS GG&C
2. **Ed Clifton**, SHTG Unit Head, Healthcare Improvement Scotland (HIS)
3. **Julie Calvert**, Lead Health Services Researcher, HIS
4. **Mark Cook**, Director of Re-imburement and Government Affairs, Assn. of British Healthcare Industries
5. **Kate Dion**, HIS Public Partner
6. **Karen Facey**, Evidence Based Health Policy Consultant
7. **Claire Fernie**, HIS Public Partner
8. **Rodolfo Hernández**, Research Fellow at HE Research Unit, University of Aberdeen
9. **Fatim Lakha**, Consultant, Public Health Scotland
10. **Colin Marsland**, Director of Finance, NHS Shetland
11. **Jennifer McGowan (On behalf of Katie Hislop)**, Sponsorship Officer, Directorate for the Chief Operating Officer, Scottish Government

#### Apologies

- **Safia Qureshi**, Director of Evidence and Digital, HIS
- **Katie Hislop**, Healthcare Quality and Improvement Directorate, DG Health & Social Care, Scottish Government

#### Topic Experts

- **Dr Nicholas Cruden**, Consultant Cardiologist, NHS Lothian

#### External Observers

- **Natalie Hallas**, Health Economics, Policy and Reimbursement Manager, Medtronic
- **Theresa Marshall**, Health Economics Manager, Medtronic
- **Andrew Moyes**, Clinical Coordinator, University Wishaw Hospital, NHS Lanarkshire
- **John McLean**, Deputy Head of MRI Physics, NHS Greater Glasgow and Clyde
- **Sophie Barnett**, HEPR Program Director, Medtronic

#### SHTG & HIS Attendees

- **Jenny Harbour** - Health Service Researcher, HIS
- **Rohan Deogaonkar** - Senior Health Economist, HIS
- **James Stewart** - Programme Manager, HIS
- **Tammy Nicol** - Senior Project Officer, HIS

### **Welcome and apologies**

Neil Smart, Council Chair, welcomed everyone to the meeting and noted apologies.

The meeting was noted as quorate. (Quorum is 50% plus one member.)

Observers and topic experts were welcomed.

Previous minutes were formally accepted noting a correction to spelling in one instance.

### **Declarations of Interest**

No declarations of interests were noted from the Council members.

The clinical expert's declarations of interest were displayed on screen during the meeting.

### **Transcatheter Aortic Valve Replacement (TAVI) in patients at low surgical risk**

Neil Smart introduced the topic and highlighted previous SHTG publications on the use of TAVI in higher risk categories of patients. Neil highlighted that SHTG's advice would inform national planning decisions on the provision of TAVI in Scotland.

#### SHTG Presentation/Evidence review

Jenny Harbour and Rohan Deogaonkar presented an overview of the topic and a review of the published evidence. Following the presentation, Council members sought additional information relating to the following:

- The potential 8-fold increase in paravalvular leak and risk of pacemaker within 30 days, and whether these issues were captured in the economic evaluations. It was clarified that most studies had considered the cost of pacemaker implantations and other complications (incl. paravalvular leak). It was also clarified that neither potential risk affected the overall conclusions, and especially since evidence for the newest generation devices suggested that incremental risk of pacemaker was lower.
- The nature of potential volume-based rebates on some of the valves used within Scotland. It was clarified that this was a local procurement decision and that there is not an agreed list of prices that we can include within our report.
- The large variation in number of procedures per million (ppm) population across Scotland. It was clarified that, although ppm in Scotland is lower than rates across the rest of Europe, the local figures for Scotland may be skewed by substantial variation in populations within boards.

#### Clinical Expert Commentary

Neil welcomed Dr Nicholas Cruden to the meeting as a clinical expert. Dr Cruden provided commentary on the technology from his clinical perspective and answered questions from Council members.

## Council Discussion

The group then reviewed and discussed the key points to ensure they reflected the evidence in the main report. Suggested minor edits included:

- Refer to symptomatic severe throughout, rather than the other way around.
- Include a sub bullet point on the risk of paravalvular leaks.
- Merge the 'Clinical effectiveness' and 'Safety' sections given the blurred line between what are clinical outcomes and safety outcomes
- Clarify that the published economic evaluations used local healthcare cost data (i.e. from within the country the work was undertaken)
- Clarify that the patient and social aspects information is drawn from patients across various surgical risk categories rather than those at low risk only

The Council then moved to a closed session to formulate the final recommendations, considering the evidence base, peer review and consultation comments, and the reflections of the topic experts. In agreeing the recommendation, Council's considerations included:

1. The Council recognised that not all patients who are classed as low surgical risk are suitable for TAVI. The decision on whether TAVI is the best treatment option for each patient is made by a multidisciplinary team as part of the shared decision making process. This ensures that each patient is offered the most appropriate treatment for their individual circumstances.
2. The Council agreed that TAVI was clinically beneficial and offered an improved safety profile compared with SAVR for patients in the low surgical risk group. The Council also agreed that TAVI may lead to an improved patient experience compared with SAVR, based on quality of life evidence and qualitative studies.
3. The Council discussed the significance of people who had TAVI being more likely to experience paravalvular leaks compared with SAVR. An invited clinical expert explained that it is difficult to compare rates of paravalvular leaks between the two interventions, and that only moderate or severe leaks were likely to affect patient outcomes. The Council noted that newer TAVI valves had a lower risk of paravalvular leaks.
4. The Council asked the clinical expert for insight into the relative length of hospital stay for patients after TAVI or SAVR. The expert stated that TAVI patients tend to leave hospital after no more than a day in a general ward or outpatient clinic, whereas SAVR patients were likely to require time in intensive care and to remain on a post-surgical ward for 4–5 days.
5. The Council discussed the UK based evidence on the cost effectiveness of TAVI and how the cost of TAVI devices appeared to be a key driver of the conclusions. The Council highlighted the draft NICE late stage assessment which estimated that TAVI valves would need to cost less than £14,800 for the procedure to be cost effective for patients at all levels of surgical risk. The Council agreed that procurement decisions should be coordinated to ensure that Scotland achieves the best value when purchasing TAVI valves, taking into account the possibility of volume based rebates from device manufacturers.
6. The Council highlighted that patients with symptomatic severe aortic stenosis who are at low surgical risk represent a much larger population than those currently eligible for TAVI in Scotland (inoperable or high risk). They agreed this would present challenges for the delivery of TAVI services across NHSScotland because of limited capacity. The Council was clear in

their opinion that if capacity were to increase, then access to TAVI should be prioritised based on surgical risk, so that patients who have the fewest alternative treatment options are offered TAVI first.

7. Concerns were voiced by the Council that there appeared to be unequal access to TAVI depending on where people lived, both within Scotland and compared with other areas of the UK and Europe. A clinical expert informed the Council that the number of TAVI procedures per million population was expected to increase nationally, across all TAVI centres, to align with rates in NHS England. They also advised, specifically in relation to the potential unequal access to TAVI within Scotland, that the small number of people getting TAVI in some board areas could lead to exaggerated differences in TAVI procedures per million population. The Council agreed it was important that there was equal access to TAVI for all suitable patients living in Scotland.
8. The Council understood that patients who are categorised as low surgical risk tend to be younger and have a longer life expectancy than higher risk patients, and that life expectancy for this patient group could exceed the durability of TAVI valves. It was accepted that the results from the NOTION trial after 10 years follow up suggest this may not be an issue with newer TAVI valves.

### **Council Business**

#### **Chairs Update report (main points noted)**

- The SHTG programme remains at capacity. Available [here](#).
- Following on from previous discussions about the Council contributing to other SHTG work (i.e. beyond our recommendations) our assessment relating to prostate specific antigen (PSA) testing will be circulated to Council for their awareness and contribution.
- SHTG continues to support the ANIA programme, with four ANIA-related reviews in progress.
- Our SHTG Evidence Framework was referenced by Canada's Drug Agency (formally 'CADTH') within their HTA on Rapid AI for stroke detection.
- The Chair thanked Mark Cook for allowing representatives of SHTG the opportunity to attend the ABHI Scotland Group Meeting in November to raise awareness of our work and promote ongoing collaboration.
- We await medical director representation on SHTG Council – discussions ongoing.

#### **Next meeting**

Neil thanked Council members for their contributions. He also noted that the recommendation discussed today will be shared prior to publication. The next council meeting is scheduled for Monday 10 February 2025.

Neil then closed the meeting and thanked everyone for their attendance

#### **Future Meetings**

10<sup>th</sup> February 2025

31<sup>st</sup> March 2025

16<sup>th</sup> June 2025

25<sup>th</sup> August 2025

20<sup>th</sup> October 2025