**Interim methods and process statement for late-stage assessment consultation**

In Summer 2023, NICE were asked by DHSC to deliver Late-Stage Assessments. NICE produced an Interim Methods and Process statement in January 2024. In February 2024, in accordance with NICEs principles of transparency we then consulted with stakeholders on the Interim Methods and Process statement.

This document provides a themed response to the consultation which informed the changes to the Interim Methods and Process statement.

It does not provide answers to specific topic-related questions for ongoing or planned LSA evaluations as these may have confidential elements that we could not disclose in a public document or when the answer to the question depends on the outcome of the evaluation.

**Responses to themes**

# Engagement and consultation overview

1. A public consultation on the interim methods and process statement for late-stage assessment was held between 29th February and 28th March 2024. Stakeholders were given the opportunity to provide detailed comments and responses on all sections of the consultation document and the supporting documentation.
2. We received over 800 responses from 41 organisations and individuals. Some trade bodies were also representing others’ views. We also received supportive responses from system partners and collaborators. More details are provided in table 1.
3. It is worth noting that some external stakeholders provided numerous comments (on multiple sections and themes) within one individually submitted comment, therefore the proportion of comments was possibly greater than the figure quoted above.

Table 1 Consultation responses by organisation type

|  |  |  |
| --- | --- | --- |
| **Respondent** | **Number of organisations (or individuals)** | **Percentage (of 812 comments)** |
| Industry | 18 | 61% |
| Trade bodies/associations (representing 800 life science companies) | 5 | 15.5% |
| External Assessment Groups (EAGs) | 5 | 12% |
| NICE teams | 2 | 1%  |
| Voluntary and community sector organisations | 2 | 5% |
| NHSE & DHSE | 2 | 5%  |
| Royal colleges, academic & professional societies | 4 | 1%  |
| Arms-length bodies, NHS trusts, ICB/ICS & NHS Wales | 2 | 3%  |
| Organisations (external to NICE) that didn’t fit into other categories | 1 | 0.5% |

1. Key themes and questions that emerged from the consultation were:
* The ability of NICE to deliver rigorous guidance based on interim methods and process.
* The need for more detail in the interim methods and process statement.
* Deviation from NICE process and methods set out in the NICE health technologies evaluations; the manual.
* The interrelation between late-stage assessment and the other parts of the Medtech Strategy.
* The variability of technology categories selected for evaluation
* The use of benchmarked pricing and its impact on NICE’s reference case.
* User preference and use of Multi-criteria Decision Analysis (MCDA).

# Findings from the interim methods and process statement for late-stage assessment consultation, implications, and next steps

## Section 1 – Introduction and rationale

### Summary of comments received for section 1

1. Respondents commented on the need for more detail in the interim methods and process statement. This included the need for more detail on the deviations from the Health Technology Evaluations process and methods (PMG36) and the setting of the predetermined price range. A small number of respondents stated that significant deviation from current NICE methods and process may introduce uncertainty and bias in the final guidance.
2. Respondents stated that an iterative approach to the first late-stage assessments may lead to inconsistency in outputs between topics and may impact timelines. They also stated that there is a risk that earlier topics may not be completed to NICE’s high standards. Respondents noted that NICE should be diligent in mitigating any potential negative consequences of an iterative process.
3. Respondents requested further clarity on the rationale of late-stage assessment and how this may impact product choice for patients and clinicians. Respondents raised concerns about the potential of late-stage assessment to limit product choice in the NHS.
4. Respondents requested further detail on the remit of late-stage assessment to better understand how it will overlap with other initiatives designed to support the government’s Medtech strategy, and the role of procurement and commissioning in decision-making and how these decisions will be supported.

### Our response and any changes to the interim methods and process statement

#### Request for more detail on the interim methods and process

1. “Medical technologies” encompasses a wide range of products and variability is to be expected. NICE’s HealthTech programmes use a range of methods to account for the specifics of each topic area when assessing new technologies. Late-stage assessment is no different, and so the methods are correspondingly flexible. We have added more detail throughout the interim methods and process statement for clarity and to outline how this flexibility will be applied.

#### Deviation from the NICE health technologies evaluations methods and processes

1. The methods and processes for late-stage assessment are based on those outlined in [PMG36](https://www.nice.org.uk/process/pmg36/chapter/introduction-to-health-technology-evaluation), with necessary adjustments to adapt these principles to the unique challenges of late-stage assessment. Relevant sections of PMG36 are referenced throughout the interim methods and process statement and the interim statement is intended to provide detail on the methods and process that differ from PMG36.

#### Process and timelines for iterations on methods and recommendations

1. Please see relevant response to section 5.

#### The benefits and challenges of product choice

1. The [DHSC MedTech strategy](https://www.gov.uk/government/publications/medical-technology-strategy/medical-technology-strategy#priority-2-innovative-and-dynamic-markets-1) outlines in detail the benefits and challenges with product choice in the NHS. We recognise that having a range of products available is important to accommodate patient choice and to stimulate innovation within a category. However, it is important that variation in pricing based on claimed innovations is supported by evidence.

#### Inclusion of new technologies

1. The [DHSC’s medical technology innovation classification framework](https://www.gov.uk/government/publications/medical-technology-innovation-classification-framework/medical-technology-innovation-classification-framework#defining-innovation) defines different forms of innovation. LSA is designed to evaluate categories of technologies in widespread use. It is anticipated that some of the technologies within the category will have undergone continuous improvement or incremental innovation or will be ‘copycat devices’ that do not differ in clinical function to others on the market. It is not designed to address transformative or radical innovations, which would be evaluated through NICE’s other Healthtech approaches. Products with transformative or radical innovations identified during the assessment may be referred to topic intelligence for further consideration and potential routing to a different NICE output.

#### Interrelation with the Medtech Strategy

1. Late-stage assessments stem from the Government’s inaugural [Medical Technology Strategy](https://www.gov.uk/government/publications/medical-technology-strategy/medical-technology-strategy), which contains the ambition to deliver ‘class based’ evaluations for health technology. It also aligns with NICE’s ongoing transformation work and the development of its lifecycle approach to the evaluation of health technologies. In April 2024, the Government published the [MedTech Strategy: One Year On](https://assets.publishing.service.gov.uk/media/6614fa3fc4c84de468346ab5/E03094135_Medtech_Strategy_Update_Report_v06_Web_Accessible.pdf). This sets out achievements over the last year and next steps, in collaboration with system partners, to streamline and integrate the innovation pathway for health tech. It details how LSAs fit within this ongoing pathway work, under the ‘Approvals’ section.

#### How the LSA topic choices align with NHSE priorities, such as the MedTech Funding Mandate and Specialised Services Devices Programme

1. DHSC and NICE have engaged broadly across NHSE programmes and plan to continue strategic join up as the work develops. NHSE were also invited to provide feedback during consultation.
2. LSA is a new approach across a broad range of topics to help develop a sustainable, overarching methodology that captures a fuller view of the costs and value associated with products, and how these apply to different operating models.

#### How the LSAs will be linked to further DHSC Medtech Directorate work in relation to Part IX of the Drug Tariff?

1. LSAs are part of a broader portfolio of work within the Government’s inaugural [MedTech Strategy](https://www.gov.uk/government/publications/medical-technology-strategy/medical-technology-strategy). This strategy also encompasses work to refresh how Part IX of the Drug Tariff operates. The methodology and outcomes of the LSAs may be taken into account if applicable to Part IX. For example, it may have a bearing on the categorisation of products and the development of quality attributes. The MedTech directorate will therefore ensure alignment in timings with any amendments taken forward on Part IX. Any amendments that are taken forward will happen gradually, with review points and engagement with stakeholders, including industry, patient representatives, clinicians, and NHS organisations.
2. LSAs evaluate technologies that are in widespread or established use in the NHS to inform commissioning and procurement decisions, based on their value. NICE will assess whether technologies, or features of a technology, in a category represent value for money and whether price variations are justified by the incremental differences and advancements. Some of the products chosen for future LSAs, like colostomy bags and the wound care products, are listed on the Part IX tariff. LSAs, with their focus on value assessment, will consider patient preference and usability, and incorporate real-word evidence and expert input. This focus on value aligns with the Part IX proposals.
3. Part IX will remain a list of devices available to be prescribed in the community via the FP10 prescription route. A value for money assessment will continue to be done at a local level. The inclusion of a product on Part IX does not automatically mean it is value for money as there are many factors that prescribers have to take into account. Therefore, the outputs of the LSAs will further support local decision making.

**How LSA will support procurement decision-making**

1. Many technologies in the NHS are on procurement frameworks, meet safety standards and broad product specifications but there is no clear signal about which technologies within a category are value for money and if the value added by incremental innovation is evidence-based and justifies the price variation. LSA guidance will support procurement and commissioning decision-making by using a transparent and rigorous evidence-based approach to evaluate whether such a signal exists.

## Section 2 – Stakeholder involvement and responsibilities

### Summary of comments received for section 2

1. Respondents queried how experts and specialist committee members will be recruited and how their suitability for each topic will be assessed. Respondents also highlighted the need for experts (including patient experts, clinical experts, and experts in procurement and commissioning) and specialist committee members with a wide range of experiences in the topic area and questioned how potential conflicts of interest will be handled to reduced bias. A number of respondents specifically highlighted the importance of patient input in late-stage assessment.
2. Respondents queried how commissioning and procurements experts will be sourced and the level of involvement of these experts. Respondents stated that they should not be involved as decision makers in late-stage assessment.
3. Respondents queried how additional stakeholders, such as patient and professional organisations, will be sourced for each topic, and highlighted the importance of stakeholder engagement and input into the guidance.
4. Respondents asked for clarification around the level and type of input that companies will have during the late-stage assessment process. Respondents stated that companies should be asked to provide information about their technologies to NICE to inform scoping and the assessment.
5. A small number of respondents highlighted the need for transparency around the information used for decision making in late-stage assessment.

### Our response and any changes to the interim methods and process statement

#### Expert and specialist committee member recruitment and conflicts of interest

1. Section 2.4 of the interim statement has been amended to clarify that topic specific patient experts, clinical experts and specialist committee members will be recruited alongside standing committee members for each late-stage assessment topic. This is in line with the methods for other HealthTech outputs including standard guidance and early value assessment. Section 2.4 states that topic experts typically include clinicians or researchers using the technology or practising in the care pathway, as well as lay people with a perspective on the condition and experience of using the technology being considered. Detail has also been added to clarify that NICE will recruit experts and specialist committee members with experience of covering a wide range of technologies. Experts and specialist committee members are selected using the standard NICE policy on declaring and managing interests for NICE advisory committees.
2. NICE greatly values the inclusion of patient voice in its assessments. The public involvement programme assists the HealthTech programme in the recruitment of patient experts and specialist committee members with lived experience for late-stage assessment.
3. The standing orders and terms of reference for the medical technologies advisory committee is available on the website [here](https://www.nice.org.uk/Media/Default/Get-involved/Meetings-In-Public/MTAC/2023/MTAC%20Terms%20of%20Reference%20and%20Standing%20Orders%E2%80%99%20January%202024.pdf).

#### Involvement of commissioning and procurement experts

1. Section 2.5 states that NICE can invite commissioning and procurement experts to help clarify issues during the assessment, where appropriate. Further clarification about the roles and involvement of commissioning and procurement experts in late-stage assessment is in section 2.5. NICE will identify the relevant experts in line with the methods used for other HealthTech outputs including standard guidance and early value assessment. Section 2.5 has been amended to clarify that experts are not involved in the committee decision making process.

#### Stakeholder engagement

1. Section 2.1 of the LSA interim methods and process statement notes that many groups and individuals take part in developing guidance within NICE and externally. The groups and their roles are summarised in [section 1 of NICE’s health technology evaluation manual](https://www.nice.org.uk/process/pmg36/chapter/involvement-and-participation#participants-in-the-evaluation-process). Relevant stakeholders will be identified in line with the methods used for other HealthTech outputs such as standard guidance and early value assessment.

#### Company involvement

1. Companies (with an included technology) will have the opportunity to take part in late-stage assessment at several points in the timeline, including, scoping workshop and consultation, draft assessment report fact check, user preference assessment (where appropriate), committee meetings, public consultation and resolution. Section 2.3 of the interim statement has been amended to clarify that companies will be asked to provide a summary information on their technologies and related evidence in a request for information document. This is to inform scoping and to be used by the external assessment group in developing the external assessment report.

#### Transparency in decision making

1. Details of NICE’s principles are available on the NICE website here [Our principles | Who we are | About | NICE.](https://www.nice.org.uk/about/who-we-are/our-principles)

## Section 3 – Late-stage assessment timelines

### Summary of comments received for section 3

1. Several consultees expressed concerns about the feasibility of completing LSAs within the proposed 6-9 months’ timeframe. Stakeholders noted the need to ensure the quality and thoroughness of the assessments due to the complexity and number of technologies involved. Some comments stress the importance of having flexible timelines to accommodate the varied complexities of different technologies and to ensure thorough evaluations. Consultees also requested detailed explanations of circumstances under which timelines might change, and clearer communication of these changes to all stakeholders.
2. Furthermore, requested more information on whether NICE will have sufficient resources to deliver multiple LSAs simultaneously without affecting the quality of the assessments.
3. Finally, industry consultees expressed the desire for active participation beyond just being registered stakeholders, emphasising the importance of being fully engaged and informed throughout the assessment process.

### Our response and any changes to the interim methods and process statement

#### Timelines for the evaluation

1. Due to the nature of the late-stage assessment topics there will be a degree of flexibility in timelines (we anticipate 6-9 months as an average) however, the fundamentals of all assessment processes will be the same.The timelines have been considered carefully to allow for all work to be completed. The insights gained from the first 8 topics will help us develop the final LSA timelines.
2. As with all HealthTech outputs, flexibility in the timelines will be exercised when appropriate, for example, due to the complexity of topic, to ensure LSA guidance is robust, useful and useable.
3. Stakeholders are informed of timelines and the key dates that affect them (companies, EAGs, SCMs) and will be informed as soon as possible when there are changes to these key dates. Milestone timelines, once confirmed, are published on the guidance page.
4. NICE follows a standard approach to guidance – pre-scoping, scoping, assessment, committee meetings, and resolution ensuring rigour throughout its assessment. NICE’s role is to support robust decision-making in a timely manner and the process ensures that the balance between speed and rigour is achieved.
5. The dates for the resolution stage of the process are communicated to stakeholders along with the key dates for all stages of the process at the start of an evaluation. If there are changes to the timelines these are communicated to stakeholders at the earliest opportunity. The dates for the resolution stage of the process are not published on the NICE website as this stage of the process is only open to registered stakeholders. You can register as a stakeholder using the link provided for each topic on the [NICE website](https://www.nice.org.uk/).

#### Company involvement

1. Companies are involved in the LSA guidance process at multiple stages (pre-scoping, scoping, request for information, committee, consultation and resolution). Companies are offered numerous opportunities to input information and intelligence to make the guidance useful and useable for the system. These opportunities are similar to standard guidance and EVA and include but are not limited to:
* company engagement meetings with the NICE lead team prior to the scoping workshop
* providing feedback on the draft scope (pre scoping workshop)
* participating in the scoping workshop
* responding to Expert Advisory Group (EAG) questions
* reviewing the Assessment Report (AR)
* attending committee meetings
* providing feedback on the draft committee recommendations

#### Stakeholder engagement

1. Relevant stakeholders are identified before a topic begins and invited to register to participate at the start of an evaluation. Stakeholders are welcome to register at any point in the process, we also welcome recommendations from other registered stakeholders.
2. Please refer to Section 2.4 [PMG36](https://www.nice.org.uk/process/pmg36/resources/nice-health-technology-evaluations-the-manual-pdf-72286779244741), p43 regarding identification of stakeholders. During pre-scoping we undertake extensive research to identify relevant products and companies, we will reach out to trade bodies and companies to ensure that we have the right contacts and a broad picture of the landscape and stakeholders relevant to each topic.

#### NICE capacity to deliver the first LSAs

1. The late-stage assessments have been factored into business planning for the 2024/ 25 business year.

## Section 4 - Topic choice

### Summary of comments received for Section 4 – Topic choice

1. Some respondents requested more details on how selection criteria for individual topics are established, for example how price variation is defined, whether there are specific cut-offs for defining what constitutes high annual cost, and high annual volume. Consultees also wanted more clarification if all selection criteria needed to be met for a technology to be selected? Consultees also asked how incremental innovations and relevant performance claims that influence price increases will be assessed, especially when external factors like raw material costs are involved.
2. Finally, consultees requested more information on how topic selection for LSA will align with NICE’s new Topic Prioritisation process and whether existing procurement frameworks such as the Drug Tariff and the Specialised Services Devices Programme determine the eligibility of a technology group for LSA.

### Our response and any changes to the interim methods and process statement

#### How LSA Topic Selection fits with NICE’s current Topic Selection manual and/or its emerging Topic Prioritisation process

1. Current LSA topics have been selected by DHSC, based on system need, using the LSA topic selection criteria. They have been notified to NICE for further scoping. Based on the proposed NICE Prioritisation Board process these topics bypass stage 1 of the selection process “Stage 1 will usually be omitted where the topic is a direct formal notification from NHSE or the Department of Health and Social Care (DHSC)” - 6.3.4 of NICE integrated topic prioritisation and strategic principles. Insights from the first 8 topics will inform the final process for topic selection, including the development of detailed criteria for defining price variation, high annual cost etc. Technologies chosen do not need to meet all the LSA topic selection criteria but need to meet at least one, for example, technologies couldn’t be high cost/low volume AND low cost/high volume but could be high/cost low volume and demonstrate significant price variation.

#### Existing procurement frameworks and topic eligibility, including national level frameworks such as the Drug Tariff, the Specialised Services Devices Programme, or Supply Chain frameworks

1. The topics selected so far are either on an NHS Supply Chain Framework or the Tier IX Drug Tariff framework, which are national level frameworks. Insights from the first 8 topics will inform the final process for topic selection, including whether inclusion of the category in a national procurement framework should be a mandatory eligibility criterion and whether the timelines for renewal of a framework should be taken into account.
2. Additional topic choice criteria suggested at consultation were:
* Unwanted regional/ practice variation
* Structural barriers to new entrants to the market

### Section 4 – Scoping

### Summary of comments received for section 4 - Scoping

1. Respondents commented on the need for a consultation on the draft scope even if a scoping workshop is being held and that the length of the consultation period for the draft scope should be longer.
2. Respondents suggested more detail was needed on the purpose, roles and responsibilities related to the literature searches conducted during scoping.

### Our response and proposed changes to the interim methods and process statement

1. A 7-day consultation on the draft scope has been included in the interim process and methods statement. The wording in section 4.2 has been amended in order to clarify that the draft scope will always be consulted on, regardless of there being a scoping workshop conducted or not. The length of the consultation period was chosen in alignment with section 2.5 of NICE’s health technology evaluation manual.
2. The wording of sections 4.2 and 4.3 was also amended to clarify the purpose, roles and responsibilities with regards to the literature searches conducted during scoping.

## Section 4 - Developing guidance

### Summary of comments received for section 4 - Developing guidance

1. Respondents commented on the length of public consultation, scheduling of a second committee, opportunities for price negotiations, resolution process, guidance review process and the mandatory status of the recommendations.
2. Some respondents expressed concerns about the proposed consultation period for LSA compared to standard NICE practices. Stakeholders thought the 14-day period was insufficient. Extending the consultation period to 28 days was proposed as more appropriate.

### Our response and proposed changes to the interim process and methods statement

#### Consultation length

1. Due to pressures on the health system, it is important for NICE guidance is responsive to system needs. The timeframe for guidance production has been optimised at all steps, including consultation. The consultation period corresponds with other HealthTech programme outputs, such as Early value assessments.

#### Scheduling of second committee meetings

1. The programme manual allows the option of proceeding to issue final draft guidance after the first committee discussion in some circumstances. Please refer to section 5.8.43 of the [NICE health technology evaluations: the manual](https://www.nice.org.uk/process/pmg36/resources/nice-health-technology-evaluations-the-manual-pdf-72286779244741) for further details. However, to avoid unnecessary delays to publishing the final guidance, NICE will plan for a second committee discussion.

#### Price negotiations

1. When a technology is not recommended in the draft guidance due to its price being too high, companies will have the opportunity to suggest a change in price during the consultation.

#### Resolution process

1. The resolution process outlined in section 7.2 of [NICE’s health technology evaluation manual](https://www.nice.org.uk/process/pmg36/chapter/committee-recommendations) will be included in the LSA process.

#### LSA guidance future reviews

1. LSA guidance will not have a fixed review date, except for guidance with recommendations for use with further evidence generation, when a surveillance review will be scheduled at the end of the data collection period. Please refer to section 8 of [NICE health technology evaluations: the manual](https://www.nice.org.uk/process/pmg36/resources/nice-health-technology-evaluations-the-manual-pdf-72286779244741) for further details on the surveillance of published guidance.

#### Status of the guidance

1. The guidance does not have a funding requirement.

#### General comments

1. The scoping process undertaken as part of LSA will be in line with that described in section 2 of the NICE Health Technology Evaluation manual. The disease or health condition and the population(s) for whom the technology is being evaluated and the care pathway are always considered on a topic-specific basis.

#### Economic model identified during scoping

1. Section 4.17 of the interim statement notes that the economic evaluation has an objective to “assess the potential benefits of individual technologies or relevant features, as identified in the scope, to determine whether the incremental differences represent value for money to the NHS, based on the incremental clinical or non-clinical outcomes and costs”. Section 4.3 of the interim statement notes that “(the principal model) ... can inform or be an appropriate base for the economic evaluation”. Section 4.6.3 of the NICE Health Technology Evaluation manual states that providing an all-encompassing definition of what constitutes a high-quality model is not possible. NICE and the EAG will discuss if an identified model is appropriate in that it is usable for addressing the needs of the assessment. Detail has been added to the economic evaluation section to acknowledge that the EAG is able to amend the principal model in order to optimise its use in the assessment. The appraisal of an economic model is within the remit of the EAG and is to be described in the assessment protocol and assessment report. Technical engagement is a process specific to the single technology evaluation of medicines in the Technology Appraisals programme.

#### Patient and public involvement

1. NICE values the patient voice in its assessments, including for LSA. The Public involvement programme conducts surveys with patients and carers and assists the HealthTech programme in the recruitment of lay committee members for LSA.

## Section 4 - Evidence

### Summary of comments received for section 4 - Evidence.

1. Respondents queried the types of evidence NICE would consider, including real world evidence. Here suggestions were to consider real world evidence or consider technical evidence when other data does not exist or is less relevant to the decision problem. This was highlighted as applicable to topic areas that are known to have lower quantity and quality of evidence. In addition to this, respondents noted that smaller companies would not have had the resource to conduct or publish high quality studies. Some respondents expressed concerns around the robustness of the evaluations that are done on technologies with limited evidence quality and quantity.
2. Some comments ask about what comparator would be used for the assessments. Comments also asked to consider patient involvement in the process to ensure that patient perspectives are considered.
3. Responders felt that further detail is needed in the methods to explain when a meta-analysis will be considered for an assessment. They also noted that network meta-analyses and similar methods of indirect comparison between multiple technologies are likely to be needed in all or almost all circumstances.
4. Some responders requested that the criteria for prioritisation of studies most relevant to the decision problem be outlined. There were concerns that choosing the most relevant data might be quite subjective. Consultees requested that there was clear justification on whether studies were included or excluded. Other comments queried the process of pragmatic reviewing and whether it risks missing important information.
5. A number of comments further stressed that quality and reliability appraisal of included studies should be done for all technologies in the assessment rather than as a generalised statement.
6. Some comments asked for notice of a comment period (generally a minimum of 2 weeks’ notice) and companies asked for advanced notice through being provided with a timeline. Responders noted that the protocol developed by the EAG should be shared with stakeholders, with some comments requesting stakeholder input on this document. Other comments additionally asked for companies to be able to submit evidence for the assessment, especially evidence such as post marketing surveillance data and evidence on earlier versions of a technology.

### Our response and proposed changes to the interim methods and process statement

#### Types of evidence evaluated

1. The evidence section of the interim methods and process statement (sections 4.5 to 4.13) was restructured to aid clarity. Specifically, it was highlighted that NICE considers all types of evidence in its evaluations as outlined in [section 3 of NICE’s health technology evaluation manual](https://www.nice.org.uk/process/pmg36/chapter/evidence). This includes evidence from published and unpublished data, data from non-UK sources, databases of ongoing clinical trials, end-to-end studies, conference proceedings, and data from registries, real-world evidence and other observational sources. Section 4.6 clarifies that technical evidence, post-market surveillance data and technical assessments may be used when topics have little or no evidence, or to complement published clinical evidence. The assessment report will outline the quality and quantity of evidence as well as any areas of uncertainty in the evidence for the committee to consider in their decision making. In respect of the comments on the comparator used in the evaluation, NICE acknowledges that the comparator would be topic dependent and can be determined by the external assessment group for the economic evaluation as stated in section 4.18. In terms of patient views, section 4.37 notes that the committee will consider patient and carer views. Section 2.5 states that NICE also recruits people with lived experience to be a specialist committee member.
2. Companies provide information to NICE using a structured company request for information document. This includes a request for evidence relevant to the technologies being evaluated, including real world evidence sources. Evidence can be submitted on previous versions of the technology, if relevant. The external assessment group will make a judgement on the relevance of the evidence submitted by companies to the decision problem and whether evidence on previous technology versions would be applicable to the current version.

#### Evidence selection and prioritisation

1. The interim process and methods statement (section 4.9) was amended to clarify that when there is a large amount of relevant evidence, the EAG can prioritise studies or data it considers most valid and relevant to the decision problem presented in the scope. Following consultation, NICE have clarified that specific details of the prioritisation approach will be adapted to the needs of the topic and the evidence available. This will be initially described in the assessment protocol and refined if required in the assessment report. Reasons for de-prioritising or excluding studies will be outlined in the assessment report if appropriate.

#### Pragmatic reviews

1. Section 4.8 of the interim process and methods statement gives examples of pragmatic review approaches. Specific approaches would be outlined in the EAG’s protocol. Consultation steps on the assessment report and on the draft guidance would allow stakeholders to flag any important evidence which has been excluded. The company request for information document will also identify any evidence relevant to their technologies. When a pragmatic approach to systematic reviewing has been adopted the context and trade-offs will be made explicit in the reported search methods.

#### Quality of studies

1. The interim process and methods statement states that critical appraisal of key studies will be done in accordance with [section 3 of NICE’s health technology evaluations manual](https://www.nice.org.uk/process/pmg36/chapter/evidence). Real-world evidence should be critically appraised as described in [NICE’s real-world evidence framework](https://www.nice.org.uk/corporate/ecd9/chapter/overview). Quality assessment using validated checklists will be done for pivotal clinical studies, systematic review or meta-analysis, and key economic studies.

#### Meta-analyses and systematic reviews

1. Section 4.10 of the interim methods and process statement states that pre-existing meta-analysis or systematic review will be updated if appropriate. Section 4.11 states that a quantitative meta-analysis will be done if appropriate and any existing meta-analyses can also be reported. NICE acknowledges that not all assessments will have existing meta-analyses and that not all assessments will require a meta-analysis. If a new meta-analysis is done, the external assessment group can determine the most appropriate methodology for the data available.

#### Protocol

1. The interim process and methods statement (section 4.6) states that the EAG will develop an assessment protocol from the final scope of the evaluation. This will be published on the NICE website, unless there are extenuating circumstances where this cannot happen. As the external assessment group are producing an independent report, the protocol is not released for stakeholder comment.

#### Comment periods

1. Section 4.13 states that stakeholders will be informed of the dates of any comment period before documents are released. Reference to a notice period has been removed due to potential timeline changes but companies and stakeholders would routinely be given notice of a comment period.

## Section 4 – Economic evaluation

### Summary of comments received for section 4 – Economic evaluation

1. Stakeholders requested more detail on how the price range would be determined and utilised for decision making. Consultees also requested that more detail is added with regards to the methods for economic evaluation that would be utilised in LSA. Specifically, more detail was requested with regards to the comparator, the valuation of health benefits and willingness to pay, the inclusion of wider healthcare system costs such as the cost of disinvestment and with regards to the use of expert elicitation techniques. Some consultees also queried which methods will be used to evaluate technologies with little or no evidence.
2. Some responders were concerned that LSA would focus disproportionately on costs without taking account of all relevant outcomes.
3. Stakeholders welcomed the decision to follow the NICE reference case as described in NICE’s health technology evaluation manual but felt strongly that there should not be any deviations from the reference case without prior consultation.
4. Some responders queried the extent of patient and public involvement in the economic evaluation during LSA.

### Our response and proposed changes to the interim methods and process statement

#### Determination of price range and how it will be used

1. Late-stage assessment will consider affordability to the NHS alongside the unit costs and clinical effectiveness of individual technologies. The committee will consider affordability as part of its deliberations. This may include consideration of budget impact analyses as well as national or regional policy and procurement strategies. NHSE will provide affordability estimations to NICE. For more detail, please see the section on committee decision-making in the LSA process and methods.

#### Determining the comparator

1. The respective section was amended to clarify that the comparator will depend on the specifics of the topic area and will be chosen by the EAG.

#### Willingness to pay

1. The willingness-to-pay threshold will remain the NICE reference case of £20,000 per QALY gained in the base case. Further analysis to inform decisions on affordability may be done when necessary.

#### How and when method of economic evaluation is chosen

1. The respective section was amended in order to clarify that the approach to economic evaluation will be tailored to the topic to account for the specifics of the clinical area, available data and previous technology evaluations. This is standard practice in HealthTech and reflects the variability of value propositions for HealthTech products. Proposed work will be discussed and agreed between the NICE team and the EAG once the scope has been finalised. As there are often going to be many products and companies involved with each evaluation, considering each company’s bespoke economic model is not a good use of EAG resource. It is also very important to maintain EAG independence. As such the EAG will develop a model independently for each evaluation.
2. Companies will have the opportunity to submit economic models alongside responses to NICE requests for information. An economic model submitted by a company will not be used directly for the economic evaluation but may be used to inform the EAG’s model. Companies will have an opportunity to feedback on the chosen methodology when they are invited to comment on the assessment report (see section 4.13).
3. The criteria for choosing the type of economic evaluation are laid out in sections 4.14 to 4.24.

#### How LSA considers clinical effectiveness and costs

1. The assessment will always consider clinical effectiveness and the impact of technologies on the health and quality of life of the users. Where appropriate and the data allows, this will be investigated using cost-utility analysis. The NICE reference case states that the assessment should consider all health effects in the outcomes, whether for patients or, where relevant, carers. If it has been established that the technologies are likely to be clinically comparable, then cost-comparison analysis may be used instead. Cost-comparison analysis does not only look at the costs of the technology, but also costs associated with differing health outcomes and resource consequences (for example, managing adverse events or impacts on the care pathway), when relevant. Expert opinion or elicitation on clinical effectiveness, and user preference information can also contribute to committee decision making where appropriate. Choices made will be explained and clearly justified.

#### Determining comparability

1. Technologies may be reasonably assumed to be comparable in terms of clinical effectiveness. For example, if expert experience suggests that their usability is comparable, or evidence from the EAG’s clinical review indicates high likelihood of similar clinical effectiveness. Limitations and assumptions will be clearly stated. The Committee will determine whether it considers it likely that technologies can be treated as clinically comparable for the purposes of the assessment.

#### Economic impact of switching or disinvestment

1. All relevant costs will be considered as outlined in section 4.4 of the CHTE methods and processes. This could include the comparative costs or saving of the technologies and changes in infrastructure, use and maintenance. If appropriate, staff training costs should be included.

#### Handling of low-evidence technologies

1. There are always likely to be limitations in the evidence available to inform an evaluation and having to deliberate on limited evidence is a common scenario for HealthTech committees. It is essential that limitations in the evidence are fully described and the impact on bias and uncertainty fully characterised and ideally quantified. Committees will reach judgements about the acceptability of all the evidence according to the evaluation context (including, for example, the type of technology, evaluation or population).
2. EAGs may need to make assumptions where evidence is limited for particular technologies. These assumptions will be clearly described and justified, and where appropriate validated by users who have experience of using it in the NHS or have appropriate expertise that can be applied to the technology. Limitations and uncertainty will be described for the committee to aid its decision making (see section 4.7 in CHTE methods).
3. When the clinical data for decision making is particularly limited, a summary of all relevant costs, that can include maintenance, training, implementation and disinvestment, can be produced. Expert opinion or expert elicitation on the clinical effectiveness and resource impact of technology features or a technical assessment can be reported. Where the elicited data is to be quantitative, preference should be given to formal elicitation techniques (see section 3.3.21 to 3.3.23 of NICE’s health technology evaluation manual). A conceptual model may be developed to identify key drivers for showing additional value. A full economic evaluation may not be possible.

#### Concerns related to use of expert opinion

1. Expert elicitation will be used when other evidence for decision making are particularly limited. If the data elicited is to be quantitative, preference will be given to formal elicitation techniques. The decision on the need to include expert elicitation in the absence of other data will be on a per-topic basis. Methods used will be clearly reported.
2. Section 2.2 of the interim statement acknowledges that experts and specialist committee members will be recruited alongside standing committee members for each LSA topic. They typically include clinicians or researchers using the technology or practising in the care pathway, as well as lay people with a perspective on the condition and experience of using the technology being considered. For LSA, additional expertise may be needed and recruited, for example, procurement, commissioning, and technical experts. Detail has been added that the experts recruited should have experience with the widest possible set of technologies. Experts are selected following the NICE policy on declaring and managing interests for NICE advisory committees. Specialist committee members are full decision-making members of the committee for the topic under consideration. Experts are not decision-making members of the committee.

#### Deviation from reference case (reasons and acceptable deviations)

1. As outlined in section 4.2 of the CHTE manual, the reference case specified the methods preferred by NICE, but the committee can consider non-reference case analyses if appropriate. Deviations will be clearly specified and justified, and the likely implications quantified. The committee will discuss the weight it attaches to results of non-reference-case analyses.

#### Patient and public involvement

1. As with all other NICE assessments, patient and public involvement will be key to the final decision making. Lay specialist committee members will be recruited who have a perspective on the condition in question.

## Section 4 - User preferences

### Summary of comments received for section 4 – User preference and additional outcomes

1. Generally, respondents were supportive of NICE using more robust methods to capture user preferences. They also noted that the aims and justification for the user preference assessment process and methods were required further detail. There were some concerns about using multiple criteria decision analysis (MCDA), a decision science methodology, to capture user preferences. There were requests for NICE to consult on the methodology.
2. Additional clarity was requested on who will be involved in the user preference assessment, with asks for appropriate stakeholders to be engaged. Some respondents asked if the user preference assessment would replace usual engagement with stakeholders and asked what involvement representatives from industry and professional bodies will have in the process.
3. There were enquiries about how NICE will handle bias and disagreement among users. Respondents asked for clarity on how NICE will weight preferences from subgroups of users. They also asked how NICE will integrate the user preference findings with the health economic evaluation findings. Respondents asked if the user preference findings will influence recommendations quantitatively.
4. Respondents asked for more clarity on the reporting process, including how excluded criteria would be reported, and asked that all aspects of the user preference assessment be reported transparently. Also, they asked for clarity on how the output from the user preference assessment will be used to inform procurement frameworks external to NICE.

### Our response and any changes to the interim methods and process statement

1. We are pleased that respondents were supportive of NICE using more robust methods to capture user preferences. This is also supported by a recent report from the Department of Health and Social Care which stated that late stage assessment would consider patient preference and usability, and will incorporate real-world evidence and expert input. More detail has been added to interim process and methods statement to clarify the justification and aims for the user preference assessment (section 4.29).
2. We have added a clear definition of who will be considered ‘user(s)’ to the interim process and methods statement explaining that these will be the people who are most involved in the decision to select a technology for use (section 4.28). We reiterate that users will be selected per topic based on their experience and relevance to that topic. The group or groups of users will be identified during the scoping process. Users will be recruited at the same time as other experts and SCMs. Users will be recruited following standard NICE’s guidance on recruiting experts.
3. Stakeholders who are not identified as users will not be able to contribute to, or consult on the user preference assessment. This is in line with NICE’s usual expert opinion processes. Industry and bodies representing industry will not be involved in the development of the performance matrix by the users but will be asked to supply information to support their technology in the assessment against the matrix. This detail has been added to the interim process and methods statement (section 4.32)
4. Capturing user preferences is one part of the late stage assessment. Wider stakeholder consultation will still happen, and all stakeholders will be able to comment on the output from the user preference assessment as part of the fact-checking process.
5. While it might not always be possible to remove all sources of bias from the user preference assessment, NICE will ensure that where possible conflicts of interest are minimised and reported. For transparency agreement among the whole user group, and agreement within and between different groups of users will be reported. Efforts will be made to balance groups of users to ensure that the opinions of one group do not outweigh the other.
6. NICE will not be using the output from the user preference assessment to quantitatively adjust the willingness to pay threshold. The output will be used by committee in the same way that expert opinion is currently used. This clarification has been added to the interim process and methods statement (section 4.30).
7. We will report all aspects of the user preference assessment as fully and as transparently as possible, this will include the level of engagement with each step of the process and the amount of agreement between users and groups of users. NICE does not intend for the output to be a substitute for standard criteria used in the existing procurement framework for the category. Instead, it may be used to complement these criteria. This has been added to the interim process and methods statement (section 4.34).

## Section 4 - Committee recommendations

### Summary of comments received on section 4 - Committee recommendations and decision making

1. Many stakeholder comments were focused on how the recommendations would be made in light of:
* the benchmarked price range
* consideration of user preferences and non-clinical outcomes
* consideration of features rather than individual technologies.
1. Stakeholders particularly requested clarity on how the price range would be determined, and on what basis it would be considered to represent value for money. There was concern that LSA would focus too much on cost and would neglect clinical data or patient preference.
2. Differences in the levels of evidence between technologies was also raised, with stakeholders querying whether a minimum level of evidence needed to be demonstrated for a technology to be recommended as value for money, or whether a certain level of safety and efficacy would be assumed by inclusion in the assessment. Industry stakeholders were particularly keen for a definition of ‘sufficient evidence’. Stakeholders were strongly opposed to the concept that prices could be reduced to mitigate uncertainty in the clinical evidence base.
3. Industry stakeholders emphasised that the guidance should prioritise improved outcomes and patient benefit, grounded in robust data. They stated that uncertainty should be well described and investigated, and expressed concern that the likely high uncertainty would lead the committee to regularly conclude that there was no significant difference between technologies and so that cost differences are unjustified.
4. More detail was requested on how the CHTE manual’s section on committee decision-making applies to LSA. In particular, how methods for determining whether a new technology is cost effective versus NHS standard practice can be applied to such a different decision problem.
5. Stakeholders were also keen that implementation and adoption was considered as part of the committee’s decision-making.

### Our response and proposed changes to the interim methods and process statement

1. Many comments on the recommendations are addressed in other sections:
* Determination of price range and how it will be used
* Consideration of costs and efficacy
* How and when method of economic evaluation is chosen
* How will equivalence be determined
* Willingness to pay
* User preferences

#### How the committee will make recommendations on features of technologies

1. The committee’s considerations and recommendations for late-stage assessment are designed to facilitate decision-making based on both technology features and overall technology performance. When appropriate, the committee will make recommendations on specific technology features. Features selection will be based on the assessment of the evidence, user preference and expert advice.

#### Impact of user preference on the willingness to pay threshold

1. The willingness-to-pay threshold will remain the NICE reference case of £20,000 per QALY gained in the base case. Further analysis to inform decisions on affordability may be done when necessary. This is stated in section 4.17 of the statement. The committee can consider key user preferences and technical requirements not captured in the economic modelling that could justify price variation.

#### Not recommended recommendations

1. The recommendations for late-stage assessment focus on the level of clinical effectiveness or maximum cost at which a technology would become cost effective. These can include stating the additional value associated with an improvement in a key outcome or delivering a key feature. Where higher prices are not found to be justified by the evidence of claimed benefits, the committee can advise that the most cost-effective options are considered first.

#### Minimum level of evidence to recommend

1. As noted in the CHTE manual there are always likely to be limitations in the evidence available to inform an evaluation. The committee will reach judgements about the acceptability of all the evidence according to the evaluation context (including, for example, the type of technology, evaluation or population). As a result, there is no minimum level of evidence stated for the committee to make recommendations. As part of the recommendations and rationale, the committee will highlight where applicable, uncertainties in the evidence that could justify price variation, and whether these uncertainties could be addressed by further data collection.
2. The updated interim statement is focusing on demonstration of increased benefits that can justify variation in price.
3. Where the clinical data for decision-making is particularly limited, expert opinion or elicitation can be used to estimate clinical effectiveness or resource impact.

#### Futureproofing of the guidance

1. Where possible, late-stage assessment recommendations could define features or levels of clinical effectiveness that could justify price variation. The guidance may also highlight uncertainties in the evidence that could justify price variation and be addressed by further data collection to improve future decision making.

## Section 5 - Developing and finalising the guidance

### Summary of comments received for section 5

1. Some consultees requested additional consultation after initial feedback has been gathered and before finalising the LSA methods. Some comments highlighted the potential risk associated with using interim methods in that assessments completed under interim methods could later be considered invalid, leading to potential re-evaluations.
2. Consultees also noted that the initial 8 LSA topics assessed could result in guidance which will potentially diverge from the final methods and process, and requested more clarity on the process that will NICE provide for this to be redressed.

### Our response and any changes to the interim methods and process statement

# Section 5 - Further updates

1. NICE have consulted on the LSA interim methods and process statement and will publish a consultation paper summarising the outcome of the consultation process and FAQs on the NICE website and a revised version of the statement. After the eight initial 8 topics are completed NICE will publish and consult on the final LSA methods and process statement.
2. The Interim Methods and Process statement is an addendum to the NICE Health Technology Evaluations: The manual. The interim LSA process and methods differ in only a few aspects from the manual designed to support the aims of late-stage assessment. For points where LSA potentially diverges from the CHTE manual more detail and reassurance has been provided to stakeholders in the updated version (e.g. about the relationship between MCDA to capture user preference and health economic modelling).
3. In addition to consulting on the interim statement, NICE has allocated adequate time for stakeholders to input in different stages of the individual LSA assessments such as:
* pre-scoping
* scoping and scoping workshop
* request for information (from industry)
* committee
* consultation
* resolution (including appeal)
* This will ensure the process is rigorous, transparent and fair. All assessments will be consistent with the [NICE principles](https://www.nice.org.uk/about/who-we-are/our-principles).
1. All LSA topics will follow the same process but by nature of the differences in evidence base, pathway, stakeholders there will be subtle differences in the approach and NICE’s output. This is normal in all guidance production, especially in HealthTech. As stated in the [NICE principles](https://www.nice.org.uk/about/who-we-are/our-principles), we are required to follow our documented processes and methods and are accountable for the decisions that we make. Sometimes, however, it is appropriate to depart from the documented processes and methods for particular recommendations. When this happens, we clearly explain our rationale in the guidance or standard, or in accompanying documents.