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| Meeting date: | Monday 3 October 2022 |
| Agenda item: | 1 |
| Paper number: | A |
| Title: | SHTG Council Minutes from 13 Jun 2022 |
| Purpose: | FOR INFORMATION |

Background

This paper reports the minutes of the previous meeting.

Action required

Review for accuracy and approve.

Minutes - Scottish Health Technologies Group Council

Date 13 Jun 2022 13:00-16:00

Venue: MS Teams

Contact: his.shtg@nhs.scot

Attendance

Council Members

1. **Dr Neil Smart**, Council Chair, Consultant Anaesthetist, NHS GG&C
2. **Dr Ali Mehdi**, Council Vice Chair, Consultant Orthopaedic and Trauma Surgeon, NHS Borders
3. **Dr Paul Campbell**, Council Vice-Chair, Clinical Director, Clinical Informatics, National Services Scotland
4. **Mr Ed Clifton**, SHTG Unit Head, Healthcare Improvement Scotland (HIS)
5. **Dr Rodolfo Hernandez**, Research Fellow at HE Research Unit, University of Aberdeen
6. **Dr Karen Facey**, Evidence Based Health Policy Consultant
7. **Mr Mark Cook**, Director of Re-imburement and Government Affairs, Assn. of British Healthcare Industries
8. **Mr Colin Marsland**, Director of Finance, NHS Shetland
9. **Ms Alison Harrison**, Healthcare Quality and Improvement Directorate, DG Health & Social Care, Scottish Government (Deputy for Katie Hislop)
10. **Ms Claire Fernie**, HIS Public Partner
11. **Mr David Dunkley**, HIS Public Partner
12. **Ms Hilda Emengo**, Health Service Researcher, HIS (Deputy for Karen MacPherson)

Apologies

- **Mr Jim Miller**, Chief Executive, NHS 24
- **Dr Laura Ryan**, Medical Director NHS 24, Scottish Patient Safety Fellow
- **Ms. Katie Hislop**, Healthcare Quality and Improvement Directorate, DG Health & Social Care, Scottish Government
- **Dr Safia Qureshi**, Director of Evidence, HIS
- **Ms Karen MacPherson**, Lead Health Service Researcher, HIS

Presenters

- **Joanna Kelly**, Health Service Researcher, SHTG Team, HIS
- **Rohan Deogaonkar**, Senior Health Economist, Evidence Directorate, HIS
- **Guy Berg**, Health Economist, Evidence Directorate, HIS

Clinical Experts

- **Dr Orwa Falah** (C-EVAR topic), Consultant Vascular & Endovascular Surgeon, Edinburgh Royal Infirmary
- **Prof Julie Brittenden** (C-EVAR topic), Vascular Surgeon, Queen Elizabeth University Hospital
- **Professor Lis Neubeck** (Kardia-Mobile topic), Head of the Centre for Cardiovascular Health, School of Health and Social Care, Edinburgh Napier University
- **Professor Martin Denis** (Kardia-Mobile topic), Professor of Stroke Medicine, University of Edinburgh

Observers - External

- **Jessica Gordon**, Health Economics & Market Access Senior Specialist, Boston Scientific
- **Sarah McDowell**, Manager, Clinical Reviews, Ontario Health

- **Kristen McMartin**, Clinical Epidemiologist, Ontario Health
- **Juliana Yi**, Senior Program Advisor, Ontario Health
- **Nancy Sikich**, Director, HTA, Ontario Health
- **Maxim Souter**, Health Economics and Commissioning Manager, Medtronic
- **Hilary Gossman**, Digital Sales Manager, AliveCor Ltd
- **Sean Warren**, Business Director UK/ IRE, AliveCor Ltd
- **Wickramanayake Kapilia**, Visiting Honorary Fellow

Observers – Internal

- **Rory Maguire**, Project Officer, Evidence Directorate HIS
- **Uzma Aslam**, Senior Project Officer, Evidence Directorate, HIS

Organisers

- **Jess Kandulu**, Programme Manager, SHTG Team, HIS
- **Mary Michael**, Project Officer, SHTG Team, HIS
- **Shona Cowan**, Admin Officer, SHTG Team, HIS

| Item No | Item |
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| 1 | Welcome and opening remarks |
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The Chair welcomed members to the meeting and noted David Dunkley has recently joined the council and is attending his first meeting.

Apologies from Jim Miller, Laura Ryan, Katie Hislop and Safia Qureshi were noted.

The Chair noted particular thanks to Karen Macpherson for her excellent contribution to the work of SHTG and HIS over many years. Karen is leaving her role within HIS to take up a post within Scottish Government policy.

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

Observers and clinical experts welcomed.

Previous minutes were formally accepted.

Action notes from the previous meeting were noted: SHTG’s Recommendation in the use of closed loops systems has now been published.

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| 2 | Declarations of Interest |
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Mark Cook noted a specific, personal, financial interest in the complex EVAR topic. The Chair advised that Mark would not participate in the closed session for formulating recommendations.

Clinical experts’ declarations of interest were displayed on screen during the meeting.

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| 3 | Complex-endovascular aneurysm repair (C-EVAR) |
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The Vice-chair, Ali Mehdi introduced the topic, noting that the role of the Council was to reach recommendations on the use of the technology, taking into account the evidence and

information presented during the meeting (including published literature and clinical expert commentary).

Review of published evidence and economic modelling

In 2018 SHTG published an Evidence Review and Advice on the use of C-EVAR and NHSScotland's National Services Division (NSD) had asked for this work to be updated.

The health service researcher and senior economist presented key points from the review of the published literature.

Clinical Expert Commentary

Two clinical experts provided commentary on the technology from their clinical perspective.

Council discussion

During the discussion that followed, the Chair asked for any points of clarification on the key evidence points presented to Council.

Council considerations were captured as follows:

When formulating their recommendations, the Council took into account the published clinical effectiveness, cost effectiveness and safety evidence, as well as the views of topic experts.

1. The Council confirmed that the complex aneurysms included in this review were juxtarenal aortic aneurysms (JRAA), pararenal aortic aneurysms (PRAA), suprarenal aortic aneurysms (SRAA) or TAAA. The treatment of infrarenal aneurysms or aneurysms isolated to the thoracic aorta were not included.
2. The Council noted that the published evidence base consists of lower-level observational studies, the majority of which are prone to selection bias, with patients at higher surgical risk being offered endovascular treatment. The Council supported the need to describe all the available information along with its limitations. The Council also noted that the evidence mostly relates to the elective repair of unruptured aneurysms.
3. The Council highlighted the need for higher-quality evidence, with reference to the forthcoming UK COMplex Aneurysm Study (UK-COMPASS) that may help address some uncertainties around this topic (scheduled to complete in 2024). The lack of published information around patient views was also noted.
4. The Council acknowledged that the most robust economic evidence comes from the NICE guidelines on AAA, which excludes TAAAs, and that the analysis was limited by the lack of high-quality clinical effectiveness evidence on C-EVAR.
5. The Council noted that despite the lack of an increased evidence base since the SHTG advice from 2018, there has been an increase in the provision of C-EVAR in NHSScotland. This may be partly explained by the potential advantages offered by CEVAR, a minimally invasive approach, including shorter hospital stay. People who are treated with OSR will need postoperative care in intensive care units (ICU). The future prevalence of aortic aneurysms (AAs) is likely to increase in association with the ageing population.

6. When someone has a complex AA, the treatment options are OSR, EVAR or conservative treatment. For some people, the potential benefits of surgery (open or endovascular) may not outweigh the potential risks. The Council were in agreement that successful treatment with C-EVAR is likely to be dependent on careful patient selection. Patients will present with different risk profiles and aneurysm anatomies that will determine their best treatment option. They also highlighted that the threshold for aneurysm repair may be different in certain patient groups, for example, aneurysm rupture rates are higher in women.

7. The Council noted that the evidence review concluded that high-volume hospitals and surgeons performing higher number of procedures are associated with lower levels of perioperative mortality, and that units in NHSScotland appeared to be doing small numbers of procedures (exact numbers not available).

Closed session

When formulating the recommendations, the Council considered the published evidence alongside the insights provided by clinical experts.

Changes from the draft recommendation were discussed and agreed. The Chair advised changes would be circulated to Council members for approval.

4

Kardia-Mobile

The Vice-chair, Paul Campbell, introduced the topic noting that the role of the Council was to reach recommendations on the use of the technology, based on SHTG's adaption of recent [NICE advice](#) on the use of Kardiamobile.

The health service researcher described the adaption process to Council members, and presented key points from the evidence and the comments from topic experts.

Clinical Expert Commentary

Two clinical experts provided commentary on the technology from their clinical perspective.

Council discussion

During the discussion that followed, the Chair asked for any points of clarification on the key evidence points presented to Council.

Council considerations were captured as follows:

1. The Council noted that the 6-lead KardiaMobile® device (KardiaMobile-6L®) has extra functionality compared with the single-lead device. For example, the single-lead KardiaMobile® device sends the ECG recording wirelessly to a smartphone using high frequency sound waves, whereas the six-lead device uses Bluetooth which may be less influenced by background noise. The Council agreed that because the clinical and cost effectiveness evidence in the NICE guidance was only on the single-lead device, that the recommendation for NHSScotland should be limited to the single-lead device.

2. The Council accepted that most people find KardiaMobile® easy to use, and that the technology has the potential to improve access to care particularly for people in remote and rural areas. Consideration needs to be given to ensure equity of access across all

populations. For example, where necessary, access to a smart device should be provided alongside KardiaMobile® to ensure otherwise eligible people are not excluded.

3. The Council felt that further consideration needs to be given to the impact of KardiaMobile® on the workload of healthcare professionals using the device. Devices like KardiaMobile® have the potential to reduce overall hospital appointments. KardiaMobile® traces may be quicker to analyse than the extensive data produced from some other ambulatory ECG monitors, yet provision of KardiaMobile® may make workloads less predictable compared to other types of monitors, and there may be training requirements for some professional groups (for example, staff in primary care).

4. There is no definitive guidance in the UK on whether a diagnosis of AF should rely on a standard 12-lead ECG recording. The Council noted guidelines from the European Society of Cardiology, which state that a single-lead ECG tracing of ≥ 30 seconds or 12-lead ECG showing AF analysed by a physician with expertise in ECG rhythm interpretation is necessary to establish a definitive diagnosis of AF.

Closed session

When formulating the recommendations, the Council considered the NICE evidence, the views of topic experts as part of the adaptation process, and the insights provided by clinical experts during the meeting.

Changes from the draft recommendation were discussed and agreed. Given the very minor changes to the recommendation, the final wording was agreed during the meeting.

5 Scottish Government Report

The representative of Scottish Government advised that the Accelerated National Innovation Adoption (ANIA) project is an exciting development and has been a success in terms of the profile of SHTG in providing evidence to inform decision making.

6 Chair's update report

The chair presented an update on membership, feedback from previous meetings and recent SHTG activity.

7 Evidence Directorate Update

The Head of SHTG provided an update on recent HIS Evidence activity which is relevant to SHTG and health technologies.

8 Closing business

Chair gave final thanks to all for their contribution to the meeting.

The next meeting will be on: Monday 19 September 2022