Developing a Process for Routine Consideration of Advice on Non-Medicine Technologies across NHSScotland

Report

January 2017
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Executive summary

Situation
Healthcare Improvement Scotland was commissioned by the Scottish Government Innovation Partnership Board (IPB) to make recommendations on potential options to facilitate systematic consideration of advice and information on non-medicine technologies (NMTs) across NHS boards in the National Health Service in Scotland (NHSScotland). The focus is on advice issued by Healthcare Improvement Scotland (approximately 20 per year) and the National Institute for Health and Care Excellence (NICE) (approximately 60 per year).

Background
Currently, there is no consistent and systematic process for the consideration of NMTs guidance across NHS boards. This contrasts with similar products on new medicines which are automatically considered by each NHS board’s Area Drugs and Therapeutics Committee (ADTC) which manage the process of consideration and implementation.

The commission reflects reports to the IPB that a critical missing step in the adoption and spread of innovation in NMTs in Scotland is an agreed process to consider evidence-based advice and information.

Assessment
A mixed methods approach was adopted to achieve the objectives of the commission. The approach involved: information gathering; consultation with members of the Scottish Health Technologies Group (SHTG); focus group discussions with representatives from NHS boards, industry and public partners and; an online survey distributed to key stakeholders across NHSScotland. Each stage involved reviewing the effectiveness, appropriateness and feasibility of the model options, and resulted in an iterative refinement of potential model options.

Overall, there was strong support for developing new NHS board groups with support from a national group. A number of factors emerged as being relevant when developing and implementing the agreed model option. These included:

- promoting and encouraging local ownership, decision-making, accountability and skills
- clarity around the roles and remit of the groups involved
- adequate stakeholder engagement, and
- improving the identification and referral of high impact topics from NHS boards to SHTG for consideration.

Recommendations
Consultation with a range of stakeholders across health and social care identified that the current process of considering advice and information on NMTs is not effective and highlighted the significant disparity in the assessment and consideration of guidance relating to medicine and NMTs.
Based on information gathered, the project team present the following recommendations to the IPB to help provide a systematic approach and realise the full potential of NMTs in contributing to realistic medicine (better supporting patients in taking informed decisions about their own treatment) and improving health and care outcomes and experience in Scotland:

1. Each NHS board should ensure access to a Health and Care Technologies Committee (HCTC), which will:
   a. have a remit to routinely consider the implementation of advice and information on NMTs
   b. include appropriate expertise (from local health and care expert groups), knowledge and skill set (such as health economics, public health and social care skills) to ensure that guidance on the range of NMTs are adequately considered
   c. develop a process for recording and collecting data on safety, and
   d. develop a process for considering priority NMT topics to refer to SHTG for assessment.

2. A national oversight group should support the HCTCs and:
   a. disseminate advice and information on NMTs to HCTCs
   b. communicate effectively with each HCTC, the Medicines and Healthcare products Regulatory Agency (MHRA) and the Incident Reporting and Investigation Centre (IRIC) on safety and other NMT-related issues
   c. ensure implementation of the HCTCs by obtaining feedback from NHS boards on their establishment and development, and
   d. provide monitoring, improvement and implementation support to NHS boards.

3. SHTG should take on the role of the national oversight group and its remit should be expanded to cover the proposed role of this national group. The existing skills in health technology assessment, and representation within SHTG, mean that it represents the most appropriate national oversight group.

4. NHS boards should identify and dedicate local resources to establish HCTCs. The resources required will vary depending on existing capacity, skills and knowledge.

5. The IPB and Healthcare Improvement Scotland should consider how this should be resourced to successfully implement the agreed model option and its associated recommendations, and also to provide improvement support.

6. The IPB with the Scottish Government should encourage NHS boards to reduce the disparity in focus between NMTs and medicines, and provide guidance on how to set up HCTCs.

7. SHTG will report to the IPB and the Scottish Government on the implementation of the recommendations, once the agreed model is accepted.

**Resources required**

Additional resources will be required, at both national and local levels, to effectively implement the agreed model option and its associated recommendations.

- At local levels, the resources required will vary depending on existing capacity, skills and knowledge. Some NHS boards may already have existing groups in
place that may be adapted to ensure appropriate representation. Membership required within the HCTCs will include (but not be limited to):

- Chair
- Directors of Public Health, Finance or Health and Care
- Hospital consultants from a range of specialities
- GPs
- Pharmacists
- Innovation champions
- Social care staff, and
- Administrative support.

NHS boards should engage with other stakeholders as required. HCTCs should work in a transparent manner and ensure adequate engagement with patients and the public. Consultee comments indicated that there should be patient and public representation on HCTCs. We would strongly encourage this but acknowledge that there are a variety of existing approaches to achieving patient and public engagement already in place within boards, and therefore did not consider it appropriate at this stage to mandate patient/public membership of the group.

- At a national level, additional resources will be required to:
  - work in partnership with NHS boards and Integrated Joint boards (IJBs) to provide leadership, liaison and oversight to the establishment of HCTCs
  - provide training, implementation and improvement support to local NHS boards on the consideration of NMT guidance and safer use of NMTs and support the functions provided by the project lead, and
  - ensure effective communication and dissemination of advice and information to NHS boards and provide administrative support to the SHTG secretariat.

**Action plan**

The project team make the following suggestions about how the recommendations can be successfully implemented:

1. It is suggested that the IPB should work with the Scottish Government to consider:
   - issuing guidance to all NHS boards to help monitor the implementation and facilitate the enactment of the recommendations, and
   - allocating the resources required to support the establishment and implementation of HCTCs.

2. The national oversight group will:
   - work with NHS boards to achieve successful implementation of the recommendations, and
   - set up a system and process to evaluate how the recommendations are implemented at local levels.
1 Objectives and scope of the commission

The objectives of the commission are to:

1. recommend a model that facilitates the systematic and routine consideration and spread of advice and information (as specified in the scope) on NMTs to cover each NHS board area in Scotland
2. make recommendations on the resources and processes required to achieve successful implementation of the agreed model option, and
3. ensure the establishment of the agreed model option supports integrated health and social care.

1.1 Scope of the commission

The focus is on guidance issued by Healthcare Improvement Scotland through the SHTG (approximately 20 per year) and the NICE interventional procedures guidance (IPG) (approximately 60 per year).

2 Background

Healthcare Improvement Scotland was commissioned by the Scottish Government IPB to make recommendations on potential options to facilitate systematic consideration of advice and information on NMTs. NMTs encompass a wide range of interventions, ranging from devices (such as heart valves) and diagnostic tests (such as scanning and blood tests) to changes in organisational systems and procedures, and the use of ehealth/digital technologies within health and social care. This commission reflects reports to the IPB that a critical missing step in the adoption and spread of healthcare technology innovations in Scotland is an agreed process to consider evidence-based guidance relating to NMTs in NHS boards.

The purpose of establishing a clear and focused process is to encourage and ensure that NHS boards are systematically and consistently considering NMTs so that patients gain maximum benefit from their use and support healthcare decision-makers to use available evidence in their practice. Such a process would support the desired shift to more realistic medicine through more appropriate use of NMTs and the potential value they add in care processes.

In Scotland, SHTG is responsible for assessing evidence on selected NMTs and producing and disseminating any information and advice developed based on the evidence review. The consideration of NMT guidance and decision-making about how the guidance is implemented and adopted at local levels is the responsibility of NHS boards.

A survey of NHS boards during summer 2015 highlighted there is no consistent and systematic process for the consideration of NMT guidance across NHS boards. The consideration of NMT guidance is distributed throughout a variety of board groups, including formal and ad hoc clinical groups, dependent on NHS board area and technology type. This contrasts with similar guidance on new medicines which are automatically considered by each NHS board’s ADTC which manage the process of consideration and formulary decisions.
In May 2016, Healthcare Improvement Scotland published a strategic plan (2016–2018) for driving improvement in NMTs in Scotland. The strategic plan includes a commitment to improve the routine consideration of national guidance across Scotland.

A glossary of key definitions is provided in Appendix 1.

3 Methods

A project team was set up to achieve the objectives of the commission. A mixed methods approach was adopted and involved:

- information gathering
- consultation with SHTG members (who represent all NHS boards and relevant stakeholders)
- focus group sessions, and
- an online survey.

These stages resulted in an iterative development and refinement of model options.

Full details of membership of the project team and methods used are provided in Appendix 2. Appendix 3 shows the model options consulted on at the different stages.

4 Emerging themes

A number of themes emerged, from the different stages of the process, as being relevant when further developing and implementing the agreed model option. They include:

- **Visibility**: need for the model to have sufficient visibility and standing within NHSScotland.

- **Accountability**: support and drive from national structures and policies to implement the agreed model option and its accompanying recommendations.

- **Clarity**: around the roles and remit of the groups, and an understanding that not all NMTs can be assessed by SHTG and NICE.

- **Communication**: expanding and improving communication between national and local levels by developing effective mechanisms and channels that are routinely reviewed.

- **Local ownership**: promoting and encouraging ownership, decision-making, accountability and skills for NHS boards to develop an NMT-related process at local levels.

- **Improvement and implementation support**: monitoring and supporting NHS boards to successfully implement the agreed model option and its final recommendations.

- **Transparency**: being committed to an open approach at every stage of the process.

- **Stakeholder engagement**: adequate consideration of how to meaningfully involve patients, carers, industry, academia, clinical associations, other healthcare organisations, healthcare decision-makers and the public.
• **Efficiency**: maximising the impact of the limited available resources by improving current practice and reducing inappropriate variation and duplication across Scotland.

• **Impact**: importance of reviewing the contribution of the agreed model option and final recommendations in improving the consideration of NMT guidance and safer use of NMTs in NHSScotland.

• **Topic selection**: utilising the newly formed structures to improve the identification of high impact topics from NHS boards to SHTG for consideration.

• **Patient care**: realising the full potential of NMTs in improving patient outcomes and experience.

• **Equitable access**: sufficient flexibility of the agreed model option to ensure structured consideration of and access to the diverse range of NMTs.

5 **Results**

5.1 **Information gathering**

A literature search and survey of various healthcare systems was undertaken to identify and assess processes that have been successful at promoting local consideration of NMT guidance produced at national levels. The survey included various healthcare systems in local (NHS boards), national (United Kingdom) and international (International Network of Agencies for Health Technology Assessment (INAHTA) and European Union (EU) countries) settings. The search and survey identified a lack of systematic processes for the local consideration of NMT guidance. A number of countries had different processes that were in development. Appendix 4 shows an analysis of the responses received from a survey of INAHTA and EU countries.

Based on the information gathered from the literature and other healthcare systems, including processes in development, an initial series of model options were formulated. These comprised (see Appendix 3 for full details):

• a national group, either newly created or adding to the remit of an existing group such as SHTG or the National Planning Forum (NPF)

• a number of regional groups

• NHS board level options either based upon defined groups or an agreed set of local reporting processes, and

• status quo (no change to the current way of working).

The project team considered having an overseeing governance mechanism. Representation from industry and patients or patient groups was also considered important.

5.2 **Consultation with SHTG members**

SHTG members were consulted to review the effectiveness, appropriateness and feasibility of the potential model options, to rank them based on how successful they will be at achieving the desired objectives and to provide the rationale behind their ranking.
Setting up of either a new national group or a new NHS board group were the preferred options. Maintaining status quo was the least liked option as the members felt that it did not address the issue identified and has not worked effectively to date.

At this stage, a national level group was seen to:

- provide better co-ordination and consistency of NMT information and advice
- promote involvement and engagement with a wider range of stakeholders (particularly industry and patient representatives)
- improve the monitoring and evaluation of how NMT guidance are considered locally, and
- reduce unwarranted variation and duplication across NHS boards.

The option of establishing new NHS board groups with a remit focused on NMTs was felt would:

- maintain NHS board autonomy
- promote local decision-making and ownership
- develop local skills and knowledge, and
- be more likely to result in the implementation of recommendations.

Appendix 5 depicts the strengths and weaknesses, identified by SHTG, of the model options.

### 5.3 Consultation through focus groups

Three focus group sessions, involving 24 participants, were held in June 2016. Participants were nominated by chief executives of NHS boards and bodies across Scotland and included a variety of senior healthcare professionals across different specialties, decision-makers and public partners.

The initial series of options were refined for consultation with focus groups, based on the discussions and information gathered during consultation with SHTG (see Appendix 3 for more details). The options considered were:

- a new national group, and
- NHS board level options to either establish a new NHS board group, extend the remit of existing ADTCs or set up an individual board-structured group or process.

All options were required to include:

- co-opting in specialist skills as required to discuss the different types of NMTs.

The focus groups strongly supported the option of new board level groups with an NMT focus supported by a national group. The focus group participants felt that the proposed NHS board level options were not appropriate for smaller NHS boards and that the option of having a national group alone would not adequately address local implementation (see Appendix 6 for more details).
There was consensus that the most appropriate, feasible and effective option for NHSScotland would require a combination of board-level groups supported by a national-level group to address issues relating to implementation and adoption of guidance, monitoring, audit, communication and access to appropriate expertise. The participants suggested that this could be achieved by:

- establishing a local group in each NHS board to facilitate implementation and provide local level influence
- having access to expertise and technical knowledge through a national level group
- extending the role of the national level group to include improvement support for local implementation
- having a clear channel of communication from the national group to local groups, and
- extending the role and membership of the SHTG or adding a subgroup to the SHTG to undertake the functions of the national group.

5.4 Online survey

An online survey was carried out in July 2016 to gather wider views on the final model options. The survey was distributed across NHSScotland and other key stakeholders (see Appendix 7 for more details).

The model options were further refined for wider consultation, based on the information gathered from the focus groups (see Appendix 3 for more details). The model options comprised:

- establishing new NHS board groups with an NMT focused remit
- setting up an individual board-structured group or process, and
- having a new NHS board group with support from a national group with extended remit.

Appendix 8 provides details of the models excluded during the iterative process and the reasons why they were excluded.

A total of 154 survey responses were received from individuals with middle to senior level positions from all NHS boards, social care, industry, royal colleges and societies, patient organisations and public representatives. Overall, there was strong support of having a new NHS board group with support from a national group. Of the 148 responses to the question about selecting the most preferred model option, 108 people (73%) chose ‘having a new NHS board group with support from a national group with extended remit’ as their most preferred model option. One of the main reasons behind the selection was because the option allows local ownership, accountability and flexibility with additional support from a national group, which will promote standardisation, transparency and equitable access to information and services across NHS boards.

Twenty-four people (16%) selected the option where NHS boards would set up individual board-structured groups or processes as their most preferred model option, while 16 people (11%) selected the option of establishing new NHS board groups with an NMT focused remit (without support from a national group) as their most preferred model option.
6  Recommendations

Consultation with a range of stakeholders across health and social care identified that the current process of considering advice and information on NMTs is not effective and highlighted the significant disparity in the assessment and consideration of guidance relating to medicine and NMTs.

Based on information gathered, the project team present the following recommendations to the IPB to help provide a systematic approach and realise the full potential of NMTs in contributing to realistic medicine (better supporting patients in taking informed decisions about their own treatment) and improving health and care outcomes and experience in Scotland:

1. Each NHS board should ensure access to a Health and Care Technologies Committee (HCTC), which will:
   a. have a remit to routinely consider the implementation of advice and information on NMTs
   b. include appropriate expertise (from local health and care expert groups), knowledge and skill set (such as health economics, public health and social care skills) to ensure that guidance on the range of NMTs are adequately considered
   c. develop a process for recording, collecting and acting upon data on safety associated with the use of NMT, and
   d. develop a process for considering priority NMT topics to refer to SHTG for assessment.

2. A national oversight group should support the HCTCs and:
   a. disseminate advice and information on NMTs to HCTCs
   b. communicate effectively with each HCTC, the Medicines and Healthcare products Regulatory Agency (MHRA) and the Incident Reporting and Investigation Centre (IRIC) on safety and other NMT-related issues
   c. ensure implementation of the HCTCs by obtaining feedback from NHS boards on their establishment and development, and
   d. provide monitoring, improvement and implementation support to NHS boards.

3. SHTG should take on the role of the national oversight group and its remit should be expanded to cover the proposed role of this national group. The existing skills in health technology assessment, and representation within SHTG, mean that it represents the most appropriate national oversight group.

4. NHS boards should identify and dedicate local resources to establish HCTCs. The resources required will vary depending on existing capacity, skills and knowledge.

5. The IPB and Healthcare Improvement Scotland should consider how this should be resourced to successfully implement the agreed model option and its associated recommendations, and also to provide improvement support.

6. The IPB with the Scottish Government should encourage NHS boards to reduce the disparity in focus between NMTs and medicines, and provide guidance on how to set up HCTCs.
7. SHTG will report to the IPB and the Scottish Government on the implementation of the recommendations, once the agreed model is accepted.

7 Resources required

Additional resources will be required, at both national and local levels, to effectively implement the agreed model option and its associated recommendations (see Appendix 9 for further details).

- At local levels, the resources required will vary depending on existing capacity, skills and knowledge. Some NHS boards may already have existing groups in place that may be adapted to ensure appropriate representation. Membership required within the HCTCs should include (but not be limited to):
  - Chair
  - Directors of Public Health, Finance or Health and Care
  - Hospital Consultants from a range of specialities
  - GPs
  - Pharmacists
  - Innovation champions
  - Social care staff, and
  - Administrative support.

NHS boards should engage with other stakeholders as required. HCTCs should work in a transparent manner and ensure adequate engagement with patients and the public. Consultee comments indicated that there should be patient and public representation on HCTCs. We would strongly encourage this but acknowledge that there are a variety of existing approaches to achieving patient and public engagement already in place within boards, and therefore did not consider it appropriate at this stage to mandate patient/public membership of the group.

- At a national level, additional resources will be required to:
  - work in partnership with NHS boards and Integration Joint boards (IJBs) to provide leadership, liaison and oversight to the establishment of HCTCs
  - provide training, implementation and improvement support to local NHS boards on the consideration of NMT guidance and safer use of NMTs and support the functions provided by the project lead, and
  - ensure effective communication and dissemination of advice and information to NHS boards and provide administrative support to the SHTG secretariat.
8 Action plan

The project team make the following suggestions about how the recommendations can be successfully implemented:

1. It is suggested that the IPB should work with the Scottish Government to consider:
   a. issuing guidance to all NHS boards to help monitor the implementation and facilitate the enactment of the recommendations, and
   b. allocating the resources required to support the establishment and implementation of HCTCs.

2. The national oversight group should:
   a. work with NHS boards to achieve successful implementation of the recommendations, and
   b. set up a system and process to evaluate how the recommendations are implemented at local levels.
Appendix 1  Key definitions

**Non-medicine technologies (NMTs):** refer to healthcare interventions other than medicines, and encompass a wide range of healthcare interventions, ranging from devices and diagnostic tests to changes in treatment pathways in health and social care.

**Scottish Health Technologies Group (SHTG):** an advisory group set up to provide assistance to NHS boards when considering selected health technologies, excluding medicines. Its remit is to provide advice on the evidence about the clinical and cost effectiveness of existing and new technologies likely to have significant implications for patient care in Scotland.¹ SHTG is a multidisciplinary group and membership includes representatives from NHS boards, clinical or professional networks, academia, industry, public partners, National Procurement, Scottish Government Health and Social Care Directorates, and Healthcare Improvement Scotland.²

**SHTG Advice Statements:** outline in as consistent a manner as possible the view of the SHTG on the clinical effectiveness, safety and cost effectiveness evidence for the technology in question in the context of NHSScotland. The status of SHTG Advice Statements for NHSScotland is ‘required to consider’. SHTG advice does not override the individual responsibility of health professionals to make decisions.²

**National Institute for Health and Care Excellence (NICE):** a non-departmental public body that provides national guidance and advice, to improve health and social care, for the NHS in England and Wales.³

**NICE guidance and advice:** NICE produces a range of guidance. Two of which have status in Scotland:

- multiple technology appraisal (MTA): have a ‘required to consider’ status, and
- interventional procedures guidance (IPG): are mandatory if boards are undertaking an interventional procedure.

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Appendix 2  Membership of the project team and method used

Membership of the project team

The team comprised of five people from the SHTG secretariat (two health services researchers, one health economist and one consultant interventional radiologist) and the Scottish Government (one consultant in public health medicine). The team included:

Iain Robertson  Chair
Scottish Health Technologies Group

Sara Davies  Public Health Consultant, Patients and Quality Division
Scottish Government Health and Social Care Directorates

Susan Myles  Unit Head for Scottish Health Technologies Group/
Lead Health Economist
Healthcare Improvement Scotland

Karen Macpherson  Lead Health Services Researcher
Healthcare Improvement Scotland

Hilda Emengo  Health Services Researcher
Healthcare Improvement Scotland

Methods used

A mixed methods approach, involving information gathering, consultation with SHTG members, focus group sessions and an online survey, was adopted. The different stages of the process resulted in an iterative development and refinement of potential model options.

Information gathering

The first approach involved gathering information from the evidence base and learning from experience (international, national and local settings). Information on organisational and country experience was obtained through a survey of members of the INAHTA and some EU countries as well as discussions with key informants in local (ADTCs) and national (Wales, Northern Ireland and England) settings. An initial set of model options for routine consideration of NMTs was formulated based upon consideration of the information gathered.

SHTG consultation

In April 2016 a workshop session was held, in April 2016, for members of SHTG to consider the initial set of potential model options. SHTG members were asked to review the effectiveness, appropriateness and feasibility of the initial draft model options as well as to identify different rationales behind the ranking of options. They carried out a SWOT (strengths, weaknesses, opportunities and threats) analysis for each of the model options provided and any additional model options identified. Afterwards, they ranked the model options provided based on how successful it will be at facilitating routine consideration of information and advice relating to NMTs in NHSScotland and also provided rationale behind their ranking.

The information gathered during the workshop was used to further develop the next set of model options.
**Focus group sessions**

The consideration of the next set of model options took place through three focus group discussions, involving 24 participants, in June 2016. The focus groups consisted of persons nominated by chief executives of NHS boards, industry and public partners across NHSScotland. Participants included a variety of healthcare professionals across different specialties, decision-makers and public partners.

Background information and details about each model option was provided before each focus group session. Participants were asked to consent to taking part in the discussion before the day. During the discussion, participants were asked to review the effectiveness, appropriateness and feasibility of the potential model options and rank the model options provided based on how successful it will be at facilitating routine consideration of information and advice relating to NMTs in NHSScotland. They were also asked to consider different rationales behind their ranking.

Based on the findings obtained from the focus groups, the model options were further refined and presented for consideration through an online questionnaire survey.

**Online survey**

An online survey was carried out in July 2016 and ran for 6 weeks. A distribution list for the survey was prepared to ensure a wide spread of the survey. The survey was distributed to all NHS boards (through a variety of channels such as chief executives, innovation champions, managed clinical networks, primary care, NHS board liaison groups, medical directors and directors of public health, pharmacy, finance, planning and nursing), Scottish Government, industry, and royal colleges and societies. Participants were asked to review the effectiveness, appropriateness and feasibility of potential model options provided, based on how successful it will be at facilitating routine consideration of NMT information and advice and also provided rationale behind their ranking.
Appendix 3  Model options consulted on at different stages

INITIAL SET OF MODEL OPTIONS

OPTION 1: NATIONAL-LEVEL GROUP
- This could be:
  - **Option 1a: a new national group** or
  - **Option 1b: part of an existing national body** for example, National Planning Forum (NPF), Scottish Health Technologies Group (SHTG)
- All key stakeholders will be represented on the group (all NHS boards, Integrated Joint Boards (IJBs), SHTG, the Scottish Intercollegiate Guidelines Network (SIGN), industry representation, patients)
- Group will meet routinely to consider advice and information on NMTs
- Members of the group will be responsible for co-ordinating appropriate consideration and distribution of advice and information at their local level

OPTION 2: REGIONAL-LEVEL GROUP
- NHS boards will come together to form regional planning groups that cover the North, South-East and West of Scotland (similar to the three Regional Cancer Networks: NOSCAN, WOSCAN and SCAN)
- All key stakeholders will be represented on the group (all NHS boards, IJBs, industry representation, patients)
- Group will meet routinely to consider advice and information on NMTs
- Members of the group will be responsible for coordinating appropriate consideration and distribution of advice and information at their local level

OPTION 3: LOCAL-LEVEL GROUP OR DECISION-MAKING PROCESS
**Option 3a: NHS board-level group**
- NHS boards will establish groups that meet to routinely consider advice and information on NMTs (similar to ADTCs for medicines).
- The group will ensure that its members have appropriate expertise as regards NMTs and will determine their own terms of reference
- Group will be responsible for ensuring optimal consideration and diffusion of advice and information to appropriate persons or specialties

**Option 3b: Extend the remit of already existing or established ADTCs**
- NHS boards, with established ADTC and processes that meet routinely to consider advice and information on medicines, can choose to extend the remit of the group to include considering advice relating to NMTs
- The group will ensure that its members have appropriate expertise as regards NMTs and will determine their own terms of reference
- Group will be responsible for ensuring optimal consideration and diffusion of advice and information to appropriate persons or specialties
Option 3c: **Individual structured process and reporting systems**
- All NHS boards will be individually responsible for establishing and demonstrating that there is a process to consider advice and information on NMTs
- The boards will make decisions regarding how advice and information are considered and ensure optimal diffusion to appropriate persons or specialties

Option 3d: **Adopt either option 3a, 3b or 3c**
- Have different systems running simultaneously, with NHS boards picking the system most appropriate for them
- NHS boards can choose to adopt either options 3a, 3b or 3c

OPTION 4: **STATUS QUO**
- No change to the current way of working

ALL OPTIONS (aside option 4) will:
- be responsible for identifying and receiving recently published, evidence-based advice and information
- develop a process for considering priority topics to refer to SHTG
- provide information to an agreed body to demonstrate performance
- consider appropriate representation from industry and patients or patient groups

MODEL OPTIONS FOR CONSULTATION WITH FOCUS GROUPS
The following model options were further developed for consultation through focus group discussions, based on information gathered during the SHTG workshop:

OPTION 1: **NEW NATIONAL-LEVEL GROUP**
- All key stakeholders will be represented on the group (all NHS boards, IJBs, SHTG, SIGN, industry representation, patients)
- Group will meet routinely to consider advice and information on NMTs
- Members of the group will be responsible for co-ordinating appropriate consideration and distribution of advice and information at their local level

OPTION 2: **LOCAL-LEVEL GROUP OR DECISION-MAKING PROCESS**
Option 2a: **NHS board-level group**
- NHS boards will establish groups with a shared remit that meet to routinely consider advice and information on NMTs (similar to ADTCs for medicines).
- The group will ensure that its members have appropriate expertise as regards NMTs and will determine their own terms of reference
- Group will be responsible for ensuring optimal consideration and diffusion of advice and information to appropriate persons or specialties
Option 2b: **Extend the remit of existing ADTCs**
- NHS boards, with established ADTC and processes that meet routinely to consider advice and information on medicines, can choose to extend the remit of the group to include considering advice relating to NMTs.
- The group will ensure that its members have appropriate expertise as regards NMTs and will determine their own terms of reference.
- Group will be responsible for ensuring optimal consideration and diffusion of advice and information to appropriate persons or specialties.

Option 2c: **Individual board-structured group or process**
- All NHS boards will be individually responsible for establishing and demonstrating that there is a group or process established to consider advice and information on NMTs.
- The NHS boards will make decisions regarding how advice and information are considered and ensure optimal diffusion to appropriate persons or specialties.

**ALL OPTIONS** will:
- be responsible for identifying and receiving recently published, evidence-based advice and information on NMTs.
- develop a process for considering priority NMT topics to refer to SHTG for assessment.
- provide information to an agreed body to demonstrate performance.
- consider appropriate representation from industry and patients or patient groups.
- be responsible for co-opting specialist skills to discuss the different types of NMTs (devices, diagnostics, service delivery models and interventional procedures) as required.

**MODEL OPTIONS FOR CONSULTATION THROUGH ONLINE SURVEY**
Based on the discussions during the focus group sessions, the following model options were further refined for consultation through an online survey:

Option 1: **New NHS board-level group**
- NHS boards will work to a defined remit and framework and establish a group, with appropriate expertise, that meets to routinely consider advice and information on NMTs.
- The group will ensure that its members have appropriate expertise as regards NMTs and will determine their own terms of reference.
- The group will be responsible for ensuring optimal consideration and diffusion of advice and information to appropriate persons or specialties.

Option 2: **Individual board structured group or process**
- All NHS boards will be individually responsible for establishing and demonstrating that there is an established group or process for co-ordinating appropriate consideration and distribution of NMT-related advice and information.
The NHS boards will make decisions regarding how advice and information are considered and ensure optimal diffusion to appropriate persons or specialties.

**Option 3: New NHS board-level group + national-level group**

- NHS boards will work to a defined remit and framework and establish a group, with appropriate expertise, that meets to routinely consider advice and information on NMTs. The group will be responsible for co-ordinating appropriate consideration and distribution of advice and information.

- In addition, there will be a national level group with extended remit to support and liaise with board level groups to integrate NMTs effectively within their boards, and provide effective communication channels for the board-level groups to access and share NMT-related information and advice.

**ALL OPTIONS** will:

- be responsible for identifying and receiving recently published, evidence-based advice and information on NMTs
- develop a process for considering priority NMT topics to refer to SHTG for assessment
- provide information to an agreed body to demonstrate performance
- consider appropriate representation from industry and patients or patient groups
- be responsible for co-opting specialist skills to discuss the different types of NMTs (devices, diagnostics, service delivery models and interventional procedures) as required
Appendix 4  Analysis of responses received from International Network of Agencies for Health Technology Assessment (INAHTA) members and European Union (EU) countries

A survey of various healthcare systems, across countries and different organisations, was undertaken. The following question was sent out to members of INAHTA and some EU countries:

What systems, mechanisms or methods are used in your country to facilitate consideration, uptake and dissemination of nationally produced advice and information on non-medicines technologies (any health technology other than medicines) within local health systems?

Result

Overall, the survey identified a lack of systematic processes for consideration of NMT guidance. Two countries (10% of responses received) had a structured process for considering national advice on NMTs. A number of countries (30%) had different processes that were in development, while the majority of countries (60%) did not have an established system or process for the consideration, uptake and dissemination of nationally produced advice and information on NMTs.

Response

A total of 23 responses were received across 20 countries. The table below shows the number and proportion of countries with either: a structured process for considering NMT advice (yes); systems and processes that are in development (somewhat) or no process for the consideration of NMT guidance.

<table>
<thead>
<tr>
<th>Response</th>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countries</td>
<td>Republic of Lithuania, New Zealand</td>
<td>Wales, Northern Ireland, Australia, Finland, Brazil, Austria</td>
<td>England, Germany, Sweden, France, Uruguay, Canada, Colombia, Luxembourg, Switzerland, Portugal, Czech Republic, Denmark</td>
</tr>
<tr>
<td>Number of countries</td>
<td>2</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Proportion (%)</td>
<td>10</td>
<td>30</td>
<td>60</td>
</tr>
</tbody>
</table>

Summary of the identified process for considering NMT advice by country

**New Zealand:** An independent statutory body (the National Health Committee) is responsible for prioritising new and existing health technologies and making recommendations to the Ministry of Health. An implementation framework is built into each assessment. The framework ensures buy-in from all stakeholders and provides a logical and practical sequence of actions and utilises both formal and informal levers to achieve the best outcome.

**Republic of Lithuania:** The State Health Care Accreditation Agency (VASPVT) under the Ministry of Health is responsible for co-ordinating and implementing health technology assessments on medical devices. A committee on health technology assessments ensures appropriate dissemination within the health sector and society, and form trends of assessment, deployment and application for the technology.
### Appendix 5  Summary of findings from the Scottish Health Technologies Group (SHTG) workshop

<table>
<thead>
<tr>
<th>Options/ SWOT</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Opportunities</th>
<th>Threats</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1a new national group</strong></td>
<td>High profile Independent Better co-ordination and consistency of advice Have a focused interest Easier engagement with all stakeholders Adequate expertise</td>
<td>Lack of local ownership Less able to facilitate local adoption and implementation Lack of flexibility Not accountable and lacks statutory mandate for decisions Costs and time pressures</td>
<td>Could raise and increase awareness about SHTG Achievable Enables appropriate people to be chosen or volunteer Can create mandate to implement Easy linkage with SHTG</td>
<td>Still requires link from national to local decision making Getting ownership in boards Time and cost constraints</td>
<td>Split between 1 and 6</td>
</tr>
<tr>
<td><strong>1b part of an existing national body</strong></td>
<td>Already established structure and group High profile Existing expertise Better co-ordination and consistency of advice</td>
<td>Lack of local ownership Less able to facilitate local adoption and implementation Might interfere with existing processes and remit of group Not accountable and lacks statutory mandate for decisions Costs and time pressures</td>
<td>Could raise and increase awareness about SHTG Could speed up process between receiving and acting upon advice and information Encourage shared learning across NHS boards</td>
<td>Still requires link from national to local decision making Getting ownership in NHS boards Time and cost constraints Lack of linkage to other networks</td>
<td>4</td>
</tr>
<tr>
<td><strong>2 regional-level group</strong></td>
<td>Improved equity of access Better local flexibility and understanding of local community factors Closer to local decision making More beneficial for smaller boards Manageable size with good</td>
<td>Lack of transparency with regards to the national picture Not accountable and lacks statutory mandate for decisions Less clout - not given much more consideration by local NHS boards Not all services are regional Lack of local ownership Insufficient expertise - difficult to</td>
<td>Allows all boards to benefit – a ‘virtual’ national group ‘future proof’ May be good for technologies that would be provided and implemented regionally Good for referring topics to SHTG for consideration</td>
<td>Time, funding and budget constraints</td>
<td>5</td>
</tr>
<tr>
<td>Options/ SWOT</td>
<td>Strengths</td>
<td>Weaknesses</td>
<td>Opportunities</td>
<td>Threats</td>
<td>Rank</td>
</tr>
<tr>
<td>--------------</td>
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<td>------------</td>
<td>---------------</td>
<td>---------</td>
<td>------</td>
</tr>
</tbody>
</table>
| **3a** new NHS board-level group | New group uncluttered by previous agenda  
Maintains board autonomy and promotes local decision making  
Ensures appropriate variation  
Develops local knowledge and skill  
More likely to implement advice  
Visibility of adoption | Potential for local variation and duplication  
Lack of adequate expertise  
Cost and time constraints  
Poorer engagement with patients, public and industry | Improve NMT literacy and engagement  
Maintains local focus  
Easier to generalise to IJBs  
Increased visibility of appraisals and consideration of advice  
Will act as a landing zone  
Good for referring topics to SHTG for consideration  
Lead adopters will emerge | Time and cost constraints  
Consent of NHS boards is required | Split between 1 and 6 |
| **3b** extend the remit of already existing or established ADTCs | Already established structure and group  
Has existing knowledge of local issues  
Local ownership | Lack of public visibility  
The remit of the group may be too vast leading to a focus on medicines  
Requires additional people with the right expertise on group  
Risk of variation, duplication and inconsistency across boards  
Time and cost constraints  
May not be sustainable | Improve status of NMTs by bringing NMTs to a wider audience  
Medicines and NMTs will be considered in equal light | Medicines may continue to dominate over NMTs  
Clinicians may have conflicts of clinical interest | 3 |
| **3c** individual | More local ownership and governance structure  
Maximum engagement and | Lack of co-ordinated planning  
Less accountable  
Poorer engagement with patients, | Allow boards to develop a system to its own way for working | Could be a disincentive to industry  
Increased risks to patient | 2 |
<table>
<thead>
<tr>
<th>Options/ SWOT</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Opportunities</th>
<th>Threats</th>
<th>Rank</th>
</tr>
</thead>
</table>
| structured process and reporting systems | better chance of implementation  
Flexible - can opt in or out                                                   | public and industry  
May not be sustainable  
Risk of variation, duplication and inconsistency across boards  
Less assurance that issues are being dealt with | Low cost  
More technologies could be used if boards have more ownership                                            | safety if not co-ordinated properly across boards  
May encourage local variation                                                              |                                               |
| 3d adopt either option 3a, 3b or 3c    | More local ownership and control  
Allows flexibility among boards                                                 | Lack of clear structure  
Lack of ownership and accountability  
Failure of public, patient and industry to engage due to diversity  
Would be chaotic and harder to regulate, audit and manage  
Risk of variation, duplication and inconsistency across boards | Potential for developing local ownership and decision making  
Encourages maximum discretion  
Opportunities to learn from others                                                             | Devaluation of the work or effort  
Diminishes status of NMTs  
May be inefficient because structure is not clear and too varied                             | 7    |
| 4 status quo                           | Requires minimal change  
Maintains steady state                                                        | Not worked till date  
Lack of clarity  
Does not address issue as a gap in status quo has been identified                                       | Room to improve                                                                              | As IJBs develop, status quo might get lost                                                   | 8    |
Appendix 6  Focus group results

Focus group 1
Ten participants attended the first focus group session (seven in person and three by teleconference). After considering the model options provided in term of strengths and weakness, the participants did not want to rank the options provided when they considered that they had a better model option.

The group suggested that the most appropriate, feasible and effective option would require certain elements from some of the model options provided. They suggested having a new option with a combination of a national-level group and board-level groups to address issues relating to implementation, adoption, monitoring, audit, communication and access to appropriate expertise.

There was a consensus that a national-level group should be merged with either having a new NHS board-level group or extending the remit of existing ADTCs. However the group preferred the combination of a national level group and a new NHS board-level group and highlighted the limitations associated with extending the remit of existing ADTCs (such as the tendency for discussions to remain focused on medicines).

The group suggested that the suggested model option could be achieved by:

• having a clear channel of communication from national group to local groups
• having a national level group to provide expertise and technical knowledge
• extending the role of the national level group to include a monitoring and auditing function
• establishing a local group in each NHS board to facilitate implementation and provide local level influence, and
• extending the role and membership of the SHTG or adding a subgroup to the SHTG to achieve the functions of the proposed national group.

Focus group 2
Eleven participants attended the second focus group session (seven in person and four by teleconference). Participants raised their concern around the scale of the task and lack of clarity around roles and remit of some of the model options. They did not consider expanding the role of ADTCs as a feasible option, due to the current workload of the group. They also felt that the proposed local level options were not appropriate for smaller NHS boards. There was some support for the regional option to be reconsidered.

The participants identified and developed a ‘hybrid’ model option which they selected as their preferred model option. The hybrid model option comprised of combining a national group with either a local group or decision-making process for implementation.

The group suggested that the national group should include expert subgroups by technology type to act as expert advisors for the range of NMTs available and develop effective communication channels to provide and share information with local groups.
Focus group 3
The third focus group was carried out by teleconference. Of the seven people expected to attend the session, only three people dialled in – one of which had to leave the discussion after 30 minutes.

Two of the participants, from different NHS boards, selected having a new NHS board level group as their most preferred option and having a new national group as their least preferred option. The third participant, representing industry, selected having a new national-level group as the most preferred option and the individual board-structured group or process as the least preferred option. There was some support for the regional option to be reconsidered.
Appendix 7  
Online survey

In July 2016, an online survey, lasting for about 6 weeks was carried out, to gather wider and more representative views on the potential model options. The survey was distributed to all NHS boards (through a variety of channels such as chief executives, innovation champions, managed clinical networks, primary care, board liaison groups, medical directors and directors of public health, pharmacy, finance, planning and nursing), Scottish Government, industry, and royal colleges and societies. Participants were asked to review the effectiveness, appropriateness and feasibility of potential model options provided, based on how successful it will be at facilitating routine consideration of information and advice on NMTs.

A total of 154 responses were received. Of these, 99 responses were from NHS boards. The proportion of responses received from each NHS board is provided below. The total numbers for each ranking do not add up to 154 because not every respondent ranked all three preferences.

Results of the online survey by:

A. Choice of model option

<table>
<thead>
<tr>
<th>Model option/Ranking</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>New NHS board-level group</td>
<td>16</td>
<td>93</td>
<td>30</td>
</tr>
<tr>
<td>NHS boards will work to a defined remit and framework and establish a group, with appropriate expertise, that meets to routinely consider advice and information on NMTs. The group will be responsible for co-ordinating appropriate consideration and distribution of advice and information.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual board structured group or process</td>
<td>24</td>
<td>28</td>
<td>91</td>
</tr>
<tr>
<td>NHS boards will be individually responsible for establishing and demonstrating that there is an established group or process for coordinating appropriate consideration and distribution of NMT-related advice and information.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New NHS board-level group + national-level group</td>
<td>108</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>NHS boards will work to a defined remit and framework and establish a group, with appropriate expertise, that meets to routinely consider advice and information on NMTs. The group will be responsible for coordinating appropriate consideration and distribution of advice and information. In addition, there will be a national-level group with extended remit to support and liaise with board-level groups to integrate NMTs effectively within their boards, and provide effective communication channels for the board-level groups to access and share NMT-related information and advice.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B. Organisation

NHS boards

<table>
<thead>
<tr>
<th>#</th>
<th>NHS board</th>
<th>Proportion in numbers (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NHS Ayrshire &amp; Arran</td>
<td>7 (4.5%)</td>
</tr>
<tr>
<td>2</td>
<td>NHS Borders</td>
<td>6 (3.9%)</td>
</tr>
<tr>
<td>3</td>
<td>NHS Dumfries and Galloway</td>
<td>4 (2.6%)</td>
</tr>
<tr>
<td>4</td>
<td>NHS Fife</td>
<td>4 (2.6%)</td>
</tr>
<tr>
<td>5</td>
<td>NHS Forth Valley</td>
<td>8 (5.2%)</td>
</tr>
<tr>
<td>6</td>
<td>NHS Grampian</td>
<td>6 (3.9%)</td>
</tr>
<tr>
<td>7</td>
<td>NHS Greater Glasgow and Clyde</td>
<td>17 (11.0%)</td>
</tr>
<tr>
<td>8</td>
<td>NHS Highland</td>
<td>8 (5.2%)</td>
</tr>
<tr>
<td>9</td>
<td>NHS Lanarkshire</td>
<td>6 (3.9%)</td>
</tr>
<tr>
<td>10</td>
<td>NHS Lothian</td>
<td>11 (7.1%)</td>
</tr>
<tr>
<td>11</td>
<td>NHS Orkney</td>
<td>2 (1.3%)</td>
</tr>
<tr>
<td>12</td>
<td>NHS Shetland</td>
<td>2 (1.3%)</td>
</tr>
<tr>
<td>13</td>
<td>NHS Tayside</td>
<td>15 (9.7%)</td>
</tr>
<tr>
<td>14</td>
<td>NHS Western Isles</td>
<td>3 (1.9%)</td>
</tr>
</tbody>
</table>

Social care

1. South Ayrshire Health and Social Care Partnership (NHS)

National level and special NHS boards and bodies

1. Scottish Government
2. Healthcare Improvement Scotland
3. Scottish Ambulance Service
4. NHS National Services Scotland
5. NHS 24
6. NHS Education for Scotland
7. The State Hospitals Board for Scotland
8. Golden Jubilee National Hospital
9. Golden Jubilee Foundation

Industry

1. Boston scientific

Patient organisations

1. British Liver Trust
2. Thrombosis UK
3. Royal Hospital for Sick Children
4. Kidney Research UK
5. Pulmonary fibrosis trust
6. Centre for excellence for looked after children in Scotland
Royal colleges and societies

1. Royal College of Midwives
2. The Society & College of Radiographers

Public Partners

C. Job title

- Chief executives
- Trustees
- Medical Director and Directors of: public health, pharmacy, strategic change, nursing and care, biochemistry, finance, health and care, strategic commissioning, planning and performance, imaging
- Consultants in: public health medicine, physician, paediatrician, clinical scientist, clinical psychologist, chemical pathologist, midwife, microbiologist, radiologist, anaesthetist, neonatologist, clinical biochemist, paramedic, emergency medicine, paediatric neurologist, maxillofacial prosthodontist and technologist
- Heads of: medical physics, efficiency, improvement and innovation, strategy and performance, service, medical equipment management, research and development, audiology service, planning, operations, clinical governance and quality
- GPs
- Pharmacists
- Managers of different units including: ICT programme, eHealth, microbiology, medical physics, allied health professionals, occupational therapy, cell path, laboratory services, fleet services, clinical services, radiology services
- A range of advisors including: economic, business and national medical advisor
- Clinical leads in eHealth and medical microbiology
- Public health scientists
- Administrators
- Inspectors
- Health economist
- Public Partners
## Appendix 8  Excluded model options

### Post Scottish Health Technologies Group (SHTG) workshop

<table>
<thead>
<tr>
<th>Option #</th>
<th>Excluded model option</th>
<th>Reason</th>
</tr>
</thead>
</table>
| Option 1b | National level group as part of an existing national body (for example, national planning forum (NPF), SHTG) | • Lack of local ownership or may face challenges getting ownership in NHS boards  
• Less able to facilitate local adoption and implementation  
• Not accountable and lacks statutory mandate for any decisions  
• Costs and time pressures  
• Too much variation and replication across NHS boards  
• Project becomes part of a greater or wider agenda  
• Lack of linkage to other networks |
| Option 2 | Regional level group | • Not accountable and lacks statutory mandate for any decisions  
• Less clout compared with a national group  
• Not all services are regional  
• Lack of local ownership  
• Insufficient expertise and as a result will be difficult to manage the range of advice issued on the different forms of NMTs  
• Risks of variation and inconsistency across NHS boards  
• Costs and time pressures |
| Option 3d | Local level group or decision-making process – adopt either:  
- new NHS board level group (3a);  
- extend the remit of existing ADTCs (3b); or  
- individual structured group or process with reporting systems (3c) | • Lacks clear structure due to the highly variable and informal arrangement  
• Lack of ownership and accountability  
• Failure of the public, patients and the industry to engage due to diversity  
• Difficult to evaluate, regulate and manage  
• Poor transparency  
• Risk of variation, duplication and inconsistency across NHS boards |
| Option 4 | Status quo | • Lack of clarity  
• Does not address the current issue |
### Post focus group sessions

<table>
<thead>
<tr>
<th>Option #</th>
<th>Excluded model option</th>
<th>Reason</th>
</tr>
</thead>
</table>
| Option 1 | New national level group   | • Lack of local ownership  
• Less able to facilitate local adoption and implementation  
• Lack of flexibility for NHS boards  
• Costs and time pressures  
• Too much variation and replication across NHS boards  
• Does not address the issue identified, and would still require link from national to local decision-making |
| Option 2b| Extend the remit of existing ADTCs | • The remit of the group will be too vast  
• Requires additional people with the right expertise on the group  
• Risk of variation, duplication and inconsistency across NHS boards  
• Lack of time for clinicians to attend meetings  
• May not be sustainable  
• Medicines may continue to dominate over NMTs |
Appendix 9  Resources required

Additional resources will be required, at both national and local levels, to effectively implement the agreed model option and its associated recommendations.

- At local levels, the resources required will vary depending on existing capacity, skills and knowledge. Some NHS boards may already have existing groups in place that may be adapted to ensure appropriate representation. Membership required within the HCTCs will include (but not be limited to):
  - Chair
  - Directors of Public Health, Finance or Health and Care
  - Hospital Consultants from a range of specialities
  - GPs
  - Pharmacists
  - Innovation champions
  - Social care staff, and
  - Administrative support.

NHS boards may wish to engage other stakeholders as required. HCTCs should work in a transparent manner and ensure adequate engagement with patients and the public.

- At a national level, additional resources will be required to fulfil the following responsibilities:

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>Staff banding</th>
<th>Contract type</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work in partnership with NHS boards/JJBs and provide leadership, liaison and oversight to the establishment of HCTCs</td>
<td>One whole-time equivalent (WTE) band 8a staff</td>
<td>Fixed term</td>
<td>2 years</td>
</tr>
<tr>
<td>Provide training, implementation and improvement support to local boards on the consideration of NMT guidance and safer use of NMTs and support the functions provided by the project lead</td>
<td>One WTE band 7 staff</td>
<td>Fixed term</td>
<td>1 year</td>
</tr>
<tr>
<td>Ensure effective communication and dissemination of advice and information to NHS boards and provide administrative support to the SHTG secretariat</td>
<td>One WTE band 4 staff</td>
<td>Fixed term</td>
<td>2 years</td>
</tr>
</tbody>
</table>
## Appendix 10  Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADTC</td>
<td>Area Drugs and Therapeutics Committee</td>
</tr>
<tr>
<td>CEL</td>
<td>Chief executive letter</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>HCTC</td>
<td>Health and Care Technologies Committee</td>
</tr>
<tr>
<td>IJB</td>
<td>Integrated Joint Boards</td>
</tr>
<tr>
<td>INAHTA</td>
<td>International Network of Agencies for Health Technology Assessment</td>
</tr>
<tr>
<td>IPB</td>
<td>Innovation Partnership Board</td>
</tr>
<tr>
<td>IPG</td>
<td>Interventional procedures guidance</td>
</tr>
<tr>
<td>IRIC</td>
<td>Incident Reporting and Investigation Centre</td>
</tr>
<tr>
<td>MHRA</td>
<td>Medicines and Healthcare products Regulatory Agency</td>
</tr>
<tr>
<td>MTA</td>
<td>Multiple technology appraisals</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>NMTs</td>
<td>Non-medicine technologies</td>
</tr>
<tr>
<td>NPF</td>
<td>National Planning Forum</td>
</tr>
<tr>
<td>SHTG</td>
<td>Scottish Health Technologies Group</td>
</tr>
<tr>
<td>SWOT analysis</td>
<td>Strengths, weaknesses, opportunities and threats analysis</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole-time equivalent</td>
</tr>
</tbody>
</table>