Identifying methods used within Early Value Assessments for NICE: results of a scoping review

HTA191

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Early value assessments (EVAs) were introduced by the National Institute for Health and Care Excellence (NICE) to accelerate access to promising health technologies that have the potential to address unmet needs and contribute to the National Health Service's 10-Year Plan

The key intentions of EVAs are to: identify the available evidence on the technologies; explore if technologies could address identified unmet needs; identify important evidence gaps; and assess if technologies can be used while further evidence is generated.

There had been no overviews considering the differences and commonalities of methods used to conduct EVAs. The objective of this scoping review was to identify and describe methods used within EVA Reports to July 2024.

Read the full scoping review here

METHODS

All EVAs published up to June 2024 were identified on the NICE website and considered eligible

Potentially relevant records were screened for eligibility by one reviewer and checked by a second reviewer

Two pairs of independent reviewers extracted and checked information from each EVA using a pre-piloted form

A narrative summary with graphs and tables was developed to synthesise the extracted data

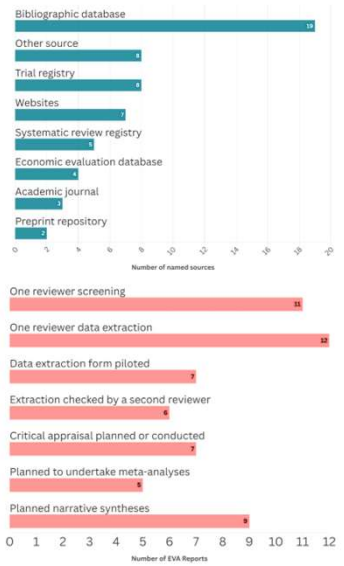
Seventeen EVA Reports were included in the scoping review: 12 from NICE's Medical Technology Evaluation Program and 5 as part of the Diagnostics Assessment Programme.
All but 3 of the included EVA Reports were **published before NICE published their interim statement on EVA methods**.

Most included EVAs assessed **one primary population** (N=13). Four included two primary populations.

The **number of subgroups** included in the EVAs ranged from 1 to 17. The final scope of two EVAs stated no subgroups were included; a further two did not report on subgroups.

The number of **interventions** assessed across the EVA Reports ranged from 1 to 14 and the number of **comparators** ranged from 1 to 21.
The number of **clinical outcomes** assessed across the EVA Reports ranged from 10 to 20 and the number of **economic outcomes** ranged from 0 to 10.

Methods for synthesising clinical effectiveness evidence



Nineteen bibliographic databases, eight trial registries and seven websites were used as sources for clinical and cost-effectiveness, with a range of other sources considered.

All 17 EVA Reports used both **MEDLINE** and **Embase**. Five EVA Reports used the **Cost-Effectiveness Analysis Registry**, five used **National Health Service Economic Evaluations Database**.

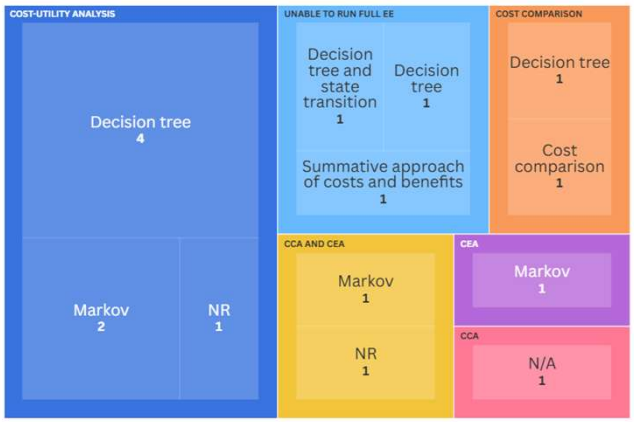
Most EVA Reports stated that they screened studies (n=11) and extracted data (N=12) with **one reviewer**. Six Reports stated that data extraction was **checked by a second reviewer** for accuracy.

Seven Reports either conducted or planned **critical appraisal** and 5 of 17 planned **meta-analyses**, even though these are not requirements of NICE EVAs.

2 Two of the 17 Reports included stated that they **involved patients and the public** in their processes

8 Eight of the 17 Reports explicitly stated methods for how **equality and equity** would be considered.

Methods for synthesising cost-effectiveness evidence



Abbreviations: CCA = cost-consequence analysis; CEA = cost-effectiveness analysis; EE = economic evaluation; N/A = not applicable; NR = not reported

Eleven of 17 EVA Reports adopted a **simplified coded model**. Eleven of 17 EVA Reports proposed a **conceptual economic model**. The most common **type of economic evaluation** performed was a cost-utility analysis (N=7). The most common **type of economic model** was a decision tree (N=6). Two EVAs did not report the type of economic model used.

1 Only 1 of the 17 EVA Reports included the **carer's perspective** on healthcare costs

4 Four of the 17 Reports **validated model inputs** alongside experts

Across 17 included EAG Reports on EVAs, there were **inconsistencies when reporting the methods used**. The methods used to undertake clinical effectiveness reviews were seldom reported or went beyond the requirements of NICE. This had an impact on the cost-effectiveness analyses.

Future Reports for EVAs should aim to be **more transparent when reporting methods**, reflecting on NICE's interim guidance. There may also be opportunities to **explore alternative and innovative methods** that could be used when the evidence base surrounding specific technologies is sparse. This may include involving key interest-holders earlier in the Report process.

References
1. National Institute for Health and Care Excellence (NICE). Early Value Assessment (EVA) for medtech. Available from: https://www.nice.org.uk/about/what-we-do/eva-for-medtech
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