EUnetHTA 21 Public Consultation
of D7.2 (guidance for patient and clinical expert input) and D7.3 (input templates)

Name organisation	Country
Alira Health	Spain
AstraZeneca	Europe Global
BAG SELBSTHILFE	Germany
Bayer AG & Bayer Vital GmbH	Germany
BEUC	Belgium
Childhood Cancer International – Europe (CCI Europe, or CCI-E)	Austria
Cancer Patients Europe (CPE)	Belgium
European Federation of Pharmaceutical Industries and Associations (EFPIA)	Belgium
European Hematology Association (EHA)	Netherlands
European Patients' Forum (EPF)	Belgium
European Society for Medical Oncology (ESMO)	Switzerland
EUCOPE	Belgium
European Organisation for Rare Diseases (Eurordis)	France
European Society of Cardiology (ESC)	France
European Union of General Practitioners/Family Physicians –(UEMO)	Belgium
F. Hoffmann-La Roche Ltd (Roche)	Switzerland
HTAi Patient and Citizen Involvement in HTA Interest Group (PCIG)	International interest group
Institut GmbH and HealthEcon AG" "IGES LifeScience"	Germany
ISPOR	Headquarters is based in the USA, but nearly 20% (1 in 5) of our membership lies within the European Union.
Lumanity	Lumanity is a global company with several European entities, including in Ireland and the Netherlands.
Lymphoma Coalition, Lymphoma Coalition Europe (LCE)	France
Medtronic	Switzerland
Myeloma Patients Europe (MPE)	Belgium, although we represent members from across EU
Osteogenesis Imperfecta Federation Europe (OIFE)	Belgium
Patient Focused Medicines Development (PFMD)	Belgium
Pancreatic Cancer Europe (PCE)	Belgium
The European Society for Paediatric Oncology (SIOP Europe, or SIOPE)	Belgium
SKC Beratungsgesellschaft mbH (SKC)	Germany
Irish Platform for Patient Organisations, Science & Industry (IPPOSI)	Ireland

Comment from	Page number	Line/ section number	Comment and suggestion for rewording D7.2 Guidance and template for the interaction with patient representative, healthcare professional and other experts	Editorial comment?	HOG answer
General comments					
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	General		Comment: We highly appreciate the involvement of external experts in the JSC and JCA in a structured and transparent manner. Apparently, several possibilities to submit relevant input into JSC and/or JCA procedures are planned. Nevertheless, here, it appears that too many distinctions and definitions of types and subtypes of KOLs and all other stakeholders – each coming along with different characteristics and requirements (including overlaps and redundancies) – could discourage or deter potentially relevant persons. Therefore, we recommend to add clear examples for each subtype and provide a flowchart to easily identify one's respective group. In addition, the respective weight of each type / subtype remains unclear. Furthermore, some additional aspects of the procedure remain to be clarified. • Patients to be involved might have problems to submit statements in English. • The maximum number of persons to be involved remains unclear. Identifying, assessing and interpreting KOL statement could lead to massive requirements in resources and become a time-intensive workstream in the overall procedures. The details of a KOL / expert database are not elaborated yet.		Thank you for your comment, we have clarified the text.
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat.	General		Comment: To improve the readability of the deliverable D7.2, we recommend to perform a thorough editorial review e.g. regarding the following issues (not exhaustive): • The used font size is not uniform throughout the document (e.g. line 40). • The text contains double spaces at various positions (e.g. line 40). • The spacing between tables, text (e.g. line 41) and different sections (e.g. lines 334-339) is not consistent. • Not all abbreviations within the text are listed in the list of abbreviations (e.g. "PICO" or "REA"). • It would be beneficial to explain abbreviations before use. For instance, the		Thank you for your comment. We are aware of the formatting issues and these will be corrected before the final publication of the deliverable.

SKC Beratungsgesellschaft mbH			abbreviation SOP (line 319) is used in the text without further explanation. • The use of capital and small initial letters should be revised (e.g. lines 108-109). • Some links are incomplete or missing (e.g. line 181, line 595). • Not all punctuations (e.g. missing comma in line 211 or missing dot in line 370) are set. • Some brackets are missing (e.g. line 236). • Double check for correct citations (e.g. line 236 – reference 34 is not given or line 411). • The use of capital and small initial letters is not uniform (e.g. table 4-1, line 348 – "online submission"). • The text contains extra characters (e.g. table 5-1, line 418 - "JJSC"). • The format and design of the text and tables is not consistent (e.g. table 5-1, centering of text; Appendix 1, space to table boundary). • The text contains listings without content (e.g. Appendix 1, in the description of Art 20(1)(b)).		
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	7	164-165	Original wording: *"External experts are individuals who have special skills or knowledge resulting from their experience or training"* Comment: We highly appreciate the involvement of external experts participating in the JSC and JCA. However, the definition of having special skills or knowledge is vague and it is unclear if people can be excluded due to lack of such skills, and by whom. Are there specific criteria excluding individuals being an external expert in this manner? We recommend to handle the selection process transparently, especially in case someone is excluded. Additionally, defined exclusion criteria may support an appropriate expert selection. In general, in can appear presumptuous to have the assessing JCA or JSC team deciding which experts to in- or exclude for input.		A section has been added to clarify the selection process of external experts
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr.	7 8	169 219	Original wording: *"A DOI is required for their involvement and there should be no major conflict of interest…"*		This comment is out of scope, as we follow the DOI guidance which is publically available

rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH			*"Any individual involved in JSC or JCA including individuals representing HTAbs (including CSCQ members and CEB), and external experts should fill out a DOI form."* Comment: We highly appreciate the formal exclusion of external experts with major conflict of interest, especially individuals representing HTAb's. Nevertheless, it needs to be considered that in orphan indications, there is usually a highly limited quantity of experts without conflict of interests. It is beneficial and appropriate for pharmaceutical manufacturers and clinical experts to communicate, especially in these challenging rare indications. Hence, we suggest not to per se exclude experts with a major conflict of interest, but rather take the circumstances into account to allow exceptions, such as "life-threatening burden of disease", "orphan indication", "highly limited response of other experts" and "highly valuable and relevant experience as guideline-publishing author". In any way, a major conflict of interest should be published in order to provide the basis for a fair decision.		
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	8	188-190	Original wording: *"In cases where the patients are less able to express themselves (e.g. children, condition inducing cognitive impairment), patients can be represented by proxies (e.g. parents, informal caregivers), ideally also with collective knowledge."* Comment: We highly appreciate the opportunity for proxies to represent impaired patients.	X	Thank you
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik	8	198	Original wording: *"Healthcare professionals working for a HTAb (participating in HTA assessments and/or consultations) or at a health technology developer should not be defined as clinical experts within the meaning of this document."*		Thank you, the text is amended

Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH			Comment: To keep objectiveness of an experts' input it is totally reasonable that these persons are not working for either an HTAb or the HTD participating in the assessment process. To reinforce this statement, we recommend to exchange the word "should" with "cannot". Suggestion for rewording: "Healthcare professionals working for a HTAb (participating in HTA assessments and/or consultations) or at a health technology developer cannot be defined as clinical experts within the meaning of this document."		
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	8 11	207 353	Original wording: *"External experts may receive access to certain documents (such as draft JCA report, submission dossier, JSC briefing package (whole or parts of it) etc.) according to the needs of the Assessor and Co-Assessor and according to the background of the expert."* *"External experts shall be given access to the information from the files submitted by the HTD to the extent necessary to answer questions from the Assessor and Co-Assessors, and in accordance with their background."* Comment: We highly appreciate the consultation of external experts and to focus on specific questions regarding their individual expertise. In the same manner, it is reasonable to restrict document access and information given to these experts according to the need and extent necessary to answer specific questions. However, the statement "*according to the needs of the Assessor and Co-Assessor*" is questionable and appears presumptuous. This strongly implies that only the (co-) assessors decide which information and documents are necessary to answer specific questions, thus transparency and independency may partially be lost. We recommend giving both the HTAb, and HTD the opportunity to decide which information is relevant and necessary for the external experts to form their opinion.		Thank you. It is important experts have access to the entire information package as they can provide relevant feedback in areas that were not anticipated by the (co-)assessors.
Prof. Matthias P. Schönermark,	8	221	Original wording: *"… external experts should fill out a DOI form."*	X	Thank you, we agree.

M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH			Comment: We appreciate that HTAbs and external experts should fill out a DOI to achieve transparency about their involvement and major conflict of interest. To reinforce this statement, we recommend to exchange the word "should" with "need to". Suggestion for rewording: *"… external experts need to fill out a DOI form."*		
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	8	220/221 vs. 211/212	Original wording: *„Any individual involved in JSC or JCA including individuals representing HTAbs (including CSCQ members and CEB) […]"* *"Any individual involved in JSC or JCA including individuals representing HTA bodies (including CSCQ JCA members and CEB) […]"* **Comment:** It is confusing reading the same sentence (see above) showing a difference in the part written in brackets. It appears that "JCA" in line 212 was written by mistake. If not written by mistake, we recommend to specify the difference between "CSCQ JCA members" and "CSCQ members". Otherwise, we recommend to delete "JCA" in line 212.	X	Thank you. We deleted JCA.
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat.	9 12	241 370	Original wording: "*If the JSC or JCA team is unable to obtain this input, this should be explained in the JSC or JCA report.*" Comment: Transparent handling of all KOL "recruitment" is appreciated. However, it is not clear at what point during the KOL contact initiation and recruitment phase the JSC or JCA team can define their approach as „unable". As an example, the question arises whether one written mail without an answer by the respective KOL would be sufficient to stop the entire process, or are at least one or two		Thank you for your comment. We agree all efforts should be made to have external expert and stakeholder involvement, and this may be further developed under the HTAR Coordination Group.

SKC Beratungsgesellschaft mbH			additional unanswered phone calls required to cancel the procedure? We recommend to specify the required unanswered contacts and define at least 2 contact attempts as the minimum.		
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	9	248	Comment: We recommend to add the national guideline developing agencies (or their respective umbrella associations) to the list of relevant organizations to be mandatorily approached by the JSC or JCA team.		Thank you, we have modified the text.
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	10 20	Section 4.1.2. 473 - 486	Comment: We agree that a database of external experts is advantageous to find suitable experts tailored for specific needs. However, to obtain a sufficient pool of external experts we suggest that the entry criteria and the effort for physicians must be adequate and attractive - their limited time should be acknowledged. Furthermore, the current draft deliverable does not consider how data are protected and which persons are authorized to handle and share personal information from the database. We recommend to include at least initial statements or working hypothesis about database security, transparency and public availability to clarify these points.		Thank you. Section 4.1.2 addresses the requirement that any database solution should be GDPR compliant
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik	13	384	Comment: The proposed thorough involvement of patients and patient associations / advocacy groups is seen highly positive, albeit one needs to await the actual involvement in the process.		Thank you.

Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH					
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	15	388	Comment: It is seen positive that experts are invited to the face-to-face meeting with HTD, HTAb and EMA to give their input. This part of the JSC is considered as being of major importance. However, previous experiences have shown that the number of interested experts can positively increase due to the possibility of a virtual participation. The high effort of a face-to-face meeting for all European experts could lead to some of them rejecting a participation. To avoid this situation, which could be accompanied by a loss of relevant and necessary input, we would highly recommend to permanently provide the option of a virtual participation of experts during the JSC.	X	Thank you for your comment. Even though the term 'face-to-face' is used does not mean the meetings are only physical meetings. Should they be in person, the expert of course will be given the opportunity to join virtually, so that we do not overburden them
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	16	393	Comment: We appreciate the listing of major points where stakeholder and expert opinions are needed during the joint clinical assessment process. To specify the time points of involvement further, we suggest adding a rough time schedule to the figure 5-2 as for example done in figure 5-1.		Defining participation times beyond the naming of the different phases is not possible for the JCA process in this form, given the various regulatory procedures for different products.

Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	20	450 Section 6.2	Comment: We appreciate the listing of contact points to easily find the right contact persons. To complete the list, we recommend adding the project manager which is mentioned in the templates (deliverable D7.3) as contact person. In addition, a clarification who is responsible for which questions (e.g. secretariat vs. project manager) should be added, in case it is relevant.	X	Thank you. It is clarified that a dedicated contact person is provided to the external expert
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	21	500	Original wording: *"Too few experts impact the applicability of the information, and a higher number of experts puts constraints on resources. For JSC and JCA taking place after EUnetHTA 21, as a minimum geographical spread should be targeted, e.g. trying to identify patient and clinical experts from southern, western, northern and eastern Europe."* Comment: We advocate the mentioned idea of targeting a geographical spread to receive as much relevant expert knowledge as possible. It remains unclear, however, to what extent the selection of experts is limited in order not to overstretch the resources and capacities. Certainly, a "first come, first serve" principle is not appropriate. We recommend to define a procedure how clinical experts are selected, especially in case of high numbers of interested experts that would exceed the given resources.		Thank you for this comment. Clarity will be provided in the text. During the recruitment period, no selection will take place. We believe this will avoid the first come first serve challenge. It would also allow selection based on potential COI, availability during critical timepoints for the JSC or JCA and, depending on the number of interested experts, the (co-)assessor may assess/decide which expert(s) are best suited for the involvement in this specific JSC/JCA

Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	21	502	Original wording: *"For JSC and JCA taking place after EUnetHTA 21, as a minimum geographical spread should be targeted, e.g. trying to identify patient and clinical experts from southern, western, northern and eastern Europe. However, recruiting experts, assessing their COI and consolidating input in a JSC or JCA takes significant resources and it may not always be possible to identify experts from each region."* Comment: As mentioned in the comment before, we appreciate trying to identify patient and clinical experts from southern, western, northern and eastern Europe. For the selection of suitable clinical experts and to receive qualified input from experts of various health care contexts, meaningful national differences should be considered.		Thank you. Since we are aiming to involve experts with collective knowledge, that can represent a community broader then their member state we have taken out the selection criteria on geographical spread.
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	25	535 Section Appendix 2	Comment: To improve the traceability and the content of the Appendix 2 of the deliverable D7.2, we recommend to perform a thorough editorial review e.g. regarding the following issues • The section to "Representatives of healthcare consumers" within the appendix is misleading, as the content of Sub-group level, Definition and Role got mixed up. • The references within the Appendix are not listed separately and therefore a transparency is not given. A listing of references with the full title would be advantageous.	X	We will consider this in the final udpate of the document
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D.,	27/28	Appendix 2	Comment: Within this table the column "Representatives of healthcare consumers" exists twice but with a shift of the inserted content between "Sub-group level 2", "Definition" and "Role". We suggest to delete the duplicate column "Representatives of healthcare consumers".	X	Thank you.

Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH					
Prof. Matthias P. Schönermark, M.D., Ph.D., Ingo Hantke, Dr. rer nat., Dominik Müller, Dr. rer. nat., Tim Ebbecke, Ph.D., Katharina Wolff, Dr. rer. nat. SKC Beratungsgesellschaft mbH	Input templates	general	Comment: Involving KOLs, experts, patients etc. in the JSC and JCA is of substantial value and therefore highly appreciated. With regard to the templates it is clearly stated that the relevant people can "*address any of the prompts that [they] feel are important and describe any other relevant issues that are not captured in the list of prompts*". This approach is supposed to guarantee the derivation of a complete picture from the interviewed person (e.g. full PICO). However, when looking at the content and extent of the different templates, it might subjectively be considered overwhelmingly extensive and thereby discourage or deter. While the JSC or JCA aim to obtain as much relevant input as possible, this approach could provoke the opposite reaction. We therefore recommend to emphasize the aforementioned statement a) in the guidance documents, b) in the input templates and c) during the "recruitment phase" of all relevant person: Albeit all aspects are important, it is not required to extensively comment on every question and prompt on the list. Rather one should focus on the aspects that are subjectively considered most important / controversial.		Thank you, we will keep this in mind and mention it where necessary. Clarification was already added to the templates.
Tanja Podkonjak, Takeda Pharmaceuticals International AG	General		Overall, Takeda welcomes the formal inclusion of patient and healthcare professional expert involvement in both the JSC and JCA procedures. While a lot of progress in developing the methods of eliciting feedback and inclusion of expert input has been considered, we felt that other guidance document was very complex and could use from being simplified and restructured to be more user-friendly and encourage participation. In particular, the distinction between 'experts' and 'stakeholders' that the guideline puts forward is not clear. For optimal uptake and involvement of the public in the JSC/JCA, it is important the guideline be kept simple and easy to understand with clear benefit to any additional complication. With this in mind,		Thank you. We will consider this when finalizing the guidance

			it is not clear what the rationale and the benefit behind this distinction is? Would the proposed differentiation preclude clinical experts who are affiliated with professional bodies (i.e., EHA) or patient experts who are affiliated with patient organisations (i.e., Lymphoma Coalition) from participating as experts? If so, this approach would preclude those who are able to represent a community of experts and arguably have the access to the most robust evidence sources from partaking. It is unclear if this is the distinction, why this distinction is made and whom it benefits. The aim of involving experts should be to have the highest quality HTA process that is relevant and representative of the EU community the technology impacts. Excluding community leaders and representatives of clinical and patient organisations is counterproductive from this objective. Furthermore, the document interchangeably refers to involvement procedures between the EUnetHTA pilots and the final HTAR procedures; it is at time difficult to follow which sections of the document refer to which procedure. We recommend an editorial review, with patient and clinical experts and expert groups, to reshape and restructure the guidance document so that it is user friendly and encourages participation from external experts. Unless the draft guidance is changed significantly, the most knowledgeable and experienced patients, caregivers, and patient group leaders will be excluded from JSC and JSA discussions and decision making.		
Tanja Podkonjak, Takeda Pharmaceuticals International AG	General		Guidance should go further in recommending how patient and clinical experts involved in an appraisal will be identified, nominated, and selected. Although the guideline suggests potential platforms to capture a pool of experts, it is not clear how patient and clinical experts for an individual JSC or JCA will be selected. This is critical to ensure that there is an objective approach to selecting the most appropriate top experts from the patient community and clinical community are involved in the appraisals, giving the JCA assessors the best available input. Clarity in the selection of experts will also contribute to more consistency between different JCA and JSC appraisals and assessor approaches. A clear nomination and selection process should address balancing		Thank you. A section has been added detailing the selection process.

			geographic representativeness and also expertise-conflict. The latter is an especially important matter for many cancers and rare diseases where there is a small number of both clinical and patient experts. Leading clinical experts are likely to be at the forefront of research on the condition in question and therefore involved in clinical trials or in giving advice to HTD on how to develop medicines. Declaration of conflict is critical and should be transparent, fully disclosed, and managed but should not in itself necessarily preclude experts from participating in the JCA or JSC procedures. A balanced and transparent approach to the selection of experts is needed and a gap in the current guidance documents.		
Tanja Podkonjak, Takeda Pharmaceuticals International AG	General		Timing of patient group consultation: Patient advocacy groups and patient experts struggle to balance a number of competing priorities, including but not limited to HTA. Many patient organizations, including those focused on rare cancers, are staffed by volunteer or part time staff. Knowledge of HTA may be limited and dedicated resources scarce. In addition, patient group leaders report that defining, sourcing, analyzing and presenting the data and insights needed for a high quality HTA submission or JSC and JSA meeting participation are both time consuming and costly. Finally, patient group leaders state that currently national HTA bodies request their input at the last moment, making it at best challenging to respond appropriately in a timely fashion. Although timelines for participation and not specified in this guidance, former proposal in the scoping guideine suggest an unfeasably short timeline for member state PICO completion (2-weeks) during which patient and clinical input should also be considered. We believe that the EUnetHTA's draft guidance for patient, caregiver and patient organization engagement should include a timeframe that is feasible for membership-based organisations to consult effectively with their patient communities. The mechanism to give input should reflect patient groups' competing priorities and available resources. This is area that requires further development and we suggest a feasible timeline be co-developed with patient advocacy groups and be clearly included in the guidance documents.		Under the HTAR, there will be a publically available annual work plan. This will help to announce, in a timely manner, when input will be sought, even though the actual input deadline may not be able to extended. A recommendation will be added to develop a notification system on EU level.

Tanja Podkonjak, Takeda Pharmaceuticals International AG	7	147-172	The distinction of patient and healthcare professionals in "stakeholders" and "individual experts" is complex without a clear value or benefit to EU HTA assessments. Takeda is concerned that the currently proposed definition "stakeholders" severely limits the involvement of patient and healthcare professional organisations and of their representatives in the JCA and JSC. Unless the draft guidance is changed, the most knowledgeable and experienced patients, caregivers, patient group leaders and clinical experts will be excluded from JSC and JSA discussions and decision making. Under the current definitions and guidance, clinical leaders from medical societies and patient leaders from patient organisation would only be able to input via a questionnaire at the scoping stage. JCA/ JSC assessors would not have access this this expertise in clarifying questions under the current definitions while they are conducting their assessments, especially JCAs. Precluding potentially the most knowledgeable bodies and individuals who have access to the most robust data sets from participating in the process seems counterproductive. Furthermore, we wish to highlight that the possible affiliation of patients or healthcare professionals to a patient network/organisation, or to a learned or medical society, should be considered as an important contributor to their expertise (in addition to training and experience) as medical knowledge increases at a fast pace. Takeda strongly recommends this section of the guidance be reconsidered and simplified to treat all experts – individuals or groups – in a consistent manner and involve the most appropriate, knowledgeable experts to be involved in the appraisals through a transparent and objective selection process.		Thank you. The definition of both stakeholders and experts has been clarified.
Tanja Podkonjak, Takeda Pharmaceuticals International AG	General		Although the guidance document puts a lot of effort in proposing the manner in which assessors can elicit feedback and input from patient and clinical experts, there is a lack of guidance on how EU HTA assessors are to consider and incorporate this evidence into the assessment process. Takeda suggest further guidance be developed to address the incorporation of expert input into JCA		The purpose of input during different time points of the JCA and JSC is provided in Table 4.1 of the guidance. Reporting of

			and JSC – this is instrumental in ensuing input is meaningful and consistently considered between assessments.		input and how it should be considered by assessors will be developed in the JSC and JCA reporting templates
Tanja Podkonjak, Takeda Pharmaceuticals International AG	General (Table 4-1 JCA and JSC, Table 5-1, pg20 line 447-449)		Elements of the current guidance place a strong reliance on existing national procedures for patient and clinical involvement (Table 4-1, scoping and PICO survey). This is a concern as currently MS have a varying level of involvement of patient and clinical experts, with some having no existing procedures or mechanisms. To ensure a robust process and that patient and clinical experts are consistently and appropriately included in JCA/JSC, we strongly recommend EUnetHTA develops explicit guidance for how MS should include and elicit expert input during for the purposes of EU HTA activities, JCA and JSC, including but not limited to the scoping step.		Thank you. The contribution of the national experts should be included in the individual position. In contrast to the involvement of the European experts, the position of the individual national experts is neither presented in the JCA report nor in the final written recommendation. The involvement of the European experts is therefore important, as they may be a valuable addition for HTA organizations that do not involve experts on a regular basis.
Tanja Podkonjak, Takeda Pharmaceuticals International AG	6	119 – 122	Current wording: “Patient and healthcare professionals can provide important knowledge about the disease and insights into treatment processes. Their input can help the assessment team select relevant outcomes or characterise the appropriate patient population and improve the relevance, legitimacy and transparency of assessments and recommendations.”		Thank you for your comment. We will consider this feedback when finalising the guidance

			Comment: Takeda believes that the current text summarising the value of patient and clinical expert input is too narrow and does not adequately reflect the value experts bring to an HTA process. Patient groups and clinical experts have proven themselves capable of providing significantly more than perspectives on outcomes and patient populations. Lending "legitimacy", as suggested, by the text falls short of describing the value of their contribution to an HTA. Their role is is critical to assist JCA/JSC assessors in interperting the data presented as the experts in the condition in question. Experts help JCA assessors understand the context of the condition, experience of patients living with the condition, the unmet need of current treatment management and its impact on their lives and how the new technology does or does not help address those issues. They also are critical in providing the EU context of data sets that are generally conducted for a global audience. Among patient groups many contributions are patient-generated data and associated insights; assessment of patients and caregivers' acceptable trade off; insights into barriers to uptake of a particular technology, e.g., side effects; a perspective on patients' experience with the broader healthcare system; and more. Patient groups have also shown themselves capable of making useful suggestions to clinical trial design, patient-relevant endpoints, etc., all essential for productive JSC discussion. Many national HTA agencies have recognised patient groups' and clinical expertise and proactively include them throughout the HTA process – from scoping, to clarifying stage, to final report recommendations. Patient groups' extensive knowledge complements the scientific knowledge of researchers and the evidence gained through preference elicitation and other methods necessary to align on relevant clinical outcomes and define the appropriate patient population for use of a technology. We recommend that the description of patient groups' and clinical experts' contributions to JSC and JSA be expanded to state the full value in the draft EUnetHTA guidance as described above. Otherwise, there is a risk of tokenism in the inclusion of patient and clinical experts in the process.		

Tanja Podkonjak, Takeda Pharmaceuticals International AG	6	156-157 170-172	Current wording in relation to stakeholder groups (i.e., patient advocacy groups): "Furthermore, financial support for their participation is not expected, as the incentive to get involved is to promote the position of one's own organisation" Current wording in relation to individual experts: "External experts may receive financial compensation for the time invested in their contribution in a future framework under the HTAR, however this is not foreseen for EUnetHTA 21." Comment: Resources and capacity required for involvment in HTA procedures is often cited as a rate limiting factor for both individual experts and advocacy groups such as patient groups. This a particular burden on smaller organizations, including those serving people with rare cancers and individual patient experts. The first statement on line 156-157 is not representative and potentially misleading regarding the objective and role of organisations such as patient advocacy groups and clinical societies in HTA. The primary objective of patient organisations and clinical organisations that participate in HTA is not to promote a specific advocacy position, but to ensure the JCA/JSC assessors have access to therapy areas expertise to understand the relevance of the data to the EU context, address any questions and above all, in the context of patient groups, enable the participation of patients in deliberations and evaluations of treatments that affect their lives. Therefore, Takeda would welcome further development of the compensation policies for patient and clinical invovlement in the EU JCA and JSC procedures by the HTA Coordination Group and the European Commission and that this include all experts – individuals and groups. This is an important aspect of ensuring good uptake and involvement of experts in the assessment process and the JCA/JSC assessors thereby having access to the best expertise in the region.		It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting compensation procedure and rules for experts participating in a JSC and/or JCA

Tanja Podkonjak, Takeda Pharmaceuticals International AG	7	154-165	Current wording: "A Declaration of Interest (DOI) form is not required for stakeholders as they are considered to have an inherent conflict, but stakeholders are required to provide information on the funding of their organisation as part of any stakeholder submission". Proposed wording: "A Declaration of Interest (DOI) form is not required for all stakeholders and they are also ~~as they are considered to have an inherent conflict, but stakeholders are~~ required to provide information on the funding of their organisation as part of any stakeholder submission". Rationale: The current language is inappropriate, contraversial and highly misleading as it implies patient advocacy groups and medical societies have a conflict for all apprasials which would impact their progressional judgement and contribution to an HTA – this is a strong, unfounded assumption and should be removed from the guidance. Takeda would like to support EFPIA's position in reminding EUnetHTA of the role patient organisations and medical societies play in the evaluation of medicines acknowledged by all EU pharmaceutical legislations and the role they have been playing in cooperating with the European Medicines Agency: -https://www.ema.europa.eu/en/partners-networks/patients-consumers; -https://www.ema.europa.eu/en/partners-networks/healthcare-professionals) Takeda recommends the same guidance and procedures be in place for stakeholder groups and individual experts (if this distinction is maintained) and that DOI be in place for all parties involved.		Thank you. This has been modified in the document
Tanja Podkonjak, Takeda Pharmaceuticals International AG	7	187-188	Takeda supports the facilitation of adequate resources to facilitate meaningful expert involvement and calls for further investment from the EC and HTACG in training of patients/HCPs who will be involved in JSC/JCA procedures. This will ensure they will be able to fully participate in the process, provide informed responses to assessor questions and provide meaningful contributions to JSC and JCAs.		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance,

			It should be noted that many experts and stakeholders may not regularly interact in HTA, a technical process that is not easy to understand to those without a background in medicine evaluations and it is important that they have a foundational understanding of the process and its intentions.		EUnetTHA 21 participates in EMA training. Additionally, the recommendation will be expanded so that in the future it can be considered to develop specific training (online modules or dedicated training meetings) for EU HTA processes
Tanja Podkonjak, Takeda Pharmaceuticals International AG	8	211-213	Current text: Any individual involved in JSC or JCA including individuals representing HTA bodies (including CSCQ JCA members and CEB) and external experts, need to sign a EUnetHTA- 21 Confidentiality Agreement (ECA) form. Proposed text: Any individual involved in JSC or JCA including individuals representing HTA bodies (including CSCQ JCA members and CEB), **stakeholder groups** and external experts, need to sign a EUnetHTA- 21 Confidentiality Agreement (ECA) form. Rationale: Due to the commerically sensitive nature of documents realted to a JCA and JSC, all individuals and organisations involved int he process should sign a confienditlaity agreement. This extends to stakeholder groups as well who under the proposed process would receive the proposed indication prior to it's approval from the EMA due to the JCA timing. The proposed indication is a highly commerical sensitive piece of information with financial and cometitive implications therefore all parties involved should be required to sign a ECA.	X	It is not envisioned that stakeholders get access to confidential information, therefore we see no need to set up such process.
Tanja Podkonjak, Takeda Pharmaceuticals	8	217-218	Current text: "Information or feedback regarding their experience of being involved in a JSC can be shared, but this must be done without revealing the content of the JSC"	X	Thank you. Experts involved in a JSC are made aware of the confidential nature of

International AG			Due to the highly sensitive nature of a JSC which includes data on the development of pipeline medicines, Takeda recommends any feedback on the JSC be limited to practical aspects that are meant to improve the process being allowed (e.g., recruitment steps, time to prepare the meeting, difficulties in understanding the questions) and not on any other aspects relating to the disease, technology, development stage etc.		the content. They sign a confidentiality agreement and there is an additional confidentiality statement included in the input templates.
Tanja Podkonjak, Takeda Pharmaceuticals International AG	9	247-262	Takeda recommends EUnetHTA consider integrating the approach for recruitment of stakeholders and external experts with reference to relevant initiatives like EUPATI, PARADIGM, and other IMI/IHI or European Commission supported projects that involved patient experts. Furthermore, allowing for nominations of experts from stakeholders in the field including medical societies, HTDs and patient umbrella organisations is recommended to be included in the guidance. In particular, involvement of patient and healthcare professional organisations in the identification of experts is critical. The knowledge of the networks and the trust of their members is a key resource that those organisations have, which should be systematically used to identify experts and representatives. The selection criteria should be clear and transparent but enabling stakeholders with knowledge of the community to put forward experts would expedite the selection process and improve the likelihood for experts being identified for all JSC and JCAs.		Text has been clarified that patient organisations and medical societies can help identify relevant external experts
Tanja Podkonjak, Takeda Pharmaceuticals International AG	11	358 - 362	Current text: “Stakeholders are mainly involved in the JCAs. For JCA, an online questionnaire can be conducted to obtain stakeholder input using the dedicated stakeholder input templates. Stakeholders, are informed of the claimed indication, but all other information in the dossier remains confidential until the JCA report is published. In JSC, stakeholders are not involved in individual consultations due to confidentiality reasons.” Comment: The current proposed inclusion of stakeholders, which under the existing definition includes patient advocacy groups and clinical societies, is overly		Thank you, we acknowledge this comment, nevertheless stakeholder organisations will not be involved in JSC in EUnetHTA 21 (and note they were not included during JA3 early dialogues either).

			restrictive and would preclude community leaders with the likely the most comprehensive knowledge and access to data from participating in the JCA and JSC process meaningfully. Not enabling JCA/JSC assessors' access to these groups may negatively impact the quality of the reports. The guidance cites confidentiality reasons as the rationale behind this approach - Takeda does not agree with this assumption. Confidentiality issues could be address through confidentiality forms signed by representatives of these groups, as is currently done in many national HTA agencies that include patient and clinical experts. Takeda requests that this section and text be reconsidered.		
Tanja Podkonjak, Takeda Pharmaceuticals International AG	16	393	Table 5.1.2 suggests "ad hoc involvement of 'European' expert, on the basis of questions from (co --) assessor throughout the procedure" Takeda questions the ad hoc approach suggested for the inclusion of experts in the JCA production process. The HTA Regulation calls for meaningful inclusion of experts in the JCA process. The current guidance only interprets this in the scoping stage and not throughout the document which is not within the spirit of the Regulation. Ad hoc inclusion will result in inconsistencies and disparities in the involvement of experts between individual JCAs and has the potential to exclude meaningful involvement from experts. Takeda strongly recommends the ad hoc approach be modified and a standard procedure be introduced via an oral hearing or meeting with JCA assessors be introduced to ensure consistent, systematic, and meaningful involvement of experts in a JCA.		Thank you, this will be rephrased.
Tanja Podkonjak, Takeda Pharmaceuticals International AG	21	506-511	Current text: "It is recommended that in the relevant Implementing Acts it is clarified that Article 11 (4) (see annex 1 for the full article) refers to all types of European involvement described in this deliverable, which provide opportunities for input from external experts into the draft JSC and JCA reports. It is not interpreted as meaning involvement in a review of a draft JSC or JCA report, as this brings challenges on confidentiality and timing." Comment:		Thank you for your comment and position. We have, however, not amended the text, as it is our interpretation. We do agree that external experts and stakeholders involved, do have an important

			Takeda strongly disagrees with this text and the interpretation of the HTA Regulation regarding the inclusion of experts in the final report production. Meaningful inclusion of experts should not be limited to scoping only as is proposed. For meaningful inclusion, experts must be present and a part of the key millstones of an JCA/JSC which includes scoping, clarifying stage or meeting and the final report. We strongly recommend this section be changed.		role in help providing context for the data submitted. External Experts also can be involved during the JSC and JCA, by answering specific questions the assessors and co-assessors may have.
James Ryan AstraZeneca	General	General	Patient and healthcare expert inclusion in HTA is critical, particularly when it comes to deliberation and providing important context of the disease, treatment and care pathway. This is particularly important at an appraisal level, and having expert inclusion at a European level should not negate or reduce the need for such inclusion at a Member State level. We believe the Guidance document would benefit from making such a statement.		In addition to the EU-level participation described in this guidance, there are also opportunities for participation at the national level (according to the rules and procedures of the national HTA bodies). However, the contribution of the national expert consultation should be included in the individual position at the discretion of the respective HTA body.
James Ryan AstraZeneca	General	General	To improve accessibility, uptake and engagement, input should take several forms and should be considerate of the needs and preferences of the experts. This could include, in addition to written feedback, testimonials, focus groups, meetings and verbal communication. To ensure communication accessibility, it is important that every document should have a lay summary so that patient advocates and non-technical		Thank you, a recommendation about this is included in the text.

			experts can understand the key content of the document they are inputting into.		
James Ryan AstraZeneca	General	General	It is important that, whenever possible, experts provide a European (or regional European) view, and not a Member State view. However, there may be certain situations, for examples, rare diseases, where limited patients or healthcare experts are available, and these views should not be dismissed.		The text will be amended to reflect there may always be an exception for (ultra) rare diseases.
James Ryan AstraZeneca	6	119-124	It is not clear what the term treatment "processes" means. For accessibility, this should be explained further e.g. treatments, treatment pathways, care pathway. It may also be beneficial to consider what patient's and healthcare professional's value and how those values are reflected (or not) by current treatments. This will help Member States understand the importance of different outcomes and the new technology benefits.		Thank you for your comment. We will consider this feedback when finalising the guidance
James Ryan AstraZeneca	7	154-157	We urge EUnetHTA 21 not to assume that experts have an inherent bias. Rather the focus should be on how can such experts provide the expertise to achieve the objectives of the Regulation, and ultimately better health outcomes across Europe. Patients can provide rich context and insight on the condition, the diversity of impact, and what matters to them. In this context, and for all stakeholders, it is inappropriate to assume that their incentive to get involved is to promote the position of one's own organisation.		Thank you, the definition for both stakeholders and experts have been clarified in the document as have their roles.
James Ryan AstraZeneca	7	182-184	Whilst we very much support the inclusion of individual patients with collective knowledge, EUnetHTA 21 may want to consider the role of determining credibility of such individuals. For example, generally a person with a leadership role in a PAG may derive credibility from the association with the PAG; however, it is less clear how to determine and validate a patient with a social media presence and connections to other patients.		Thank you for your suggestion, we have added a couple of selection criteria that can be used.
James Ryan AstraZeneca	8	188-190	Patient direct experience matters most. However, it is also important to get meaningful engagement and in some cases a caregiver can do that. Having proxy input based only upon the sole criterion of the patient's inability to express themselves may be too restrictive. For example, a patient with		Thank you for the comment. This section of the document has been modified.

			disease that is impacting QoL, may lack energy or be in pain, and this may impact their ability to meaningfully participate. In addition to the text, it is important to realise that proxies and caregivers may also have an important voice independently of the patient. Consideration beyond a patient should be made, including carers and family members, particular in those diseases where there may be substantial informal care, such as paediatrics and rare disease.		
James Ryan AstraZeneca	8	195-204	The Guidance would benefit from providing more clarity regarding the criteria required to have clinical expertise in the specific disease under discussion. For example, if a new technology is related to systemic treatment for advanced breast cancer, the HCP should have the majority of their recent experience in clinical oncology breast cancer, versus cancer more generally or breast cancer surgery. Further, we may consider that even within breast cancer, for example, there are many types as distinguished by biomarker, so again, if it is appropriate to drill down to that level for the type of disease, that should be considered.		Thank you. We have added a section on selection criteria.
James Ryan AstraZeneca	9	260	*"Public calls"* Although this may be the most transparent and fair mechanism, the public call needs to be appropriately worded and publicized in the right ways though. In addition, there should be a website run by the Secretariat that lists all the active public calls and has a way for people to "apply" so that people can all be guided to the same source and anyone tracking the HTA's work can see which calls are active and when they close. However, proactive identification of experts and patients should be considered beyond public calls, particularly for diseases that may be under-represented, for example, rare diseases.		We propose a public call in addition to pro-active identification, so it is not one or the other. We agree the website should host a list of all active public calls.
James Ryan AstraZeneca	9	261-262	We agree with the confidential nature of JSC. However, it may be possible, in some circumstances, to do a call without revealing the confidential aspects, for example, for patients and healthcare experts involved in advanced breast cancer rather than the proposed indication / clinical trial population under		In EUnetHTA 21 the decision has been made, in order to maintain confidentiality

			discussion.		of JSC, no information can be shared with stakeholders. This decision allows us to have a uniform approach for all JSC.
James Ryan AstraZeneca	11	358-362	We would like to make a general point that accessibility of documents, including templates, is paramount, and that they may need to be adjusted (including translation) for the technology and disease under discussion. It is important that the information sought is meaningful and also that the questions are worded in ways that the respondents feel confident in answering. Also, all background materials on the disease should be provided to the respondents so they have the full information as they answer questions, and each of these documents should have a lay summary so key points are easy for respondents to understand. EUnetHTA21 may want to consider getting insight from patients and HCP experts prior to designing / finalising a questionnaire for a new technology.		Section 7 of the guidance document addresses the issue of knowledge of English language in submitting input for a JSC or JCA on EU level. The template is based on the HTAi questionnaire and has been updated based on previous experience. The questionnaires have also been submitted for public consultation.
James Ryan AstraZeneca	29	Appendix 3	Ensuring that patient and healthcare expert input is meaningful and has impact will be important for the long-term sustainability of keeping external experts engaged. The questionnaire would benefit from not just asking if the respondent felt their input was taken into account, but also asking how they felt it made a meaningful difference. Importantly, the assessors should also highlight how such expert and patient input made a meaningful impact to their assessment.		Thank you. We agree feedback from assessors will be critical as more experience is gained. We also agree with your suggestion for the feedback questionnaire. These suggestions will be reflected in the guidance.

Dr. Martin Danner BAG SELBSTHILFE Germany	6	121	Patient Experts can also be helpful to judge study designs and study results concerning their relevance. Suggestion: Add "judge study design and study results" after "patient population"	no	Thank you for your comment. We will consider this feedback when finalising the guidance
Dr. Martin Danner BAG SELBSTHILFE Germany	6	122	Patient experts know very well the relevance of the comparators in medical care Suggestion: Add "and patients" after "professionals"	no	The section on general principles - value of patient/HCP involvement was revised.
Dr. Martin Danner BAG SELBSTHILFE Germany	7	154/155	Patient organisations have the interest of supporting the benefit for the patients just like the assessors of the HTA-process. So, they don't have "an inherent conflict of interest" Suggestion: Delete "as they are considered to have inherent conflict."	no	Thank you. The definition of both stakeholders and experts has been clarified.
Dr. Martin Danner BAG SELBSTHILFE Germany	7	156/157	Patient organisations have the task to identity patient experts (see lines 258 and 497 – 505!) and to explain the processes (see lines 264 – 269 and 469 – 472) and to coordinate patient participation on the national and the European level (esp. consolidation of the PICO's). Therefore financial support for the stakeholder-patient organisations is necessary. The wish to promote the position of one's own organisation does not create resources. Suggestion: Delete the sentence alter "participation" and add "is necessary to enable especially patient organisations to identity patient experts, to explain the processes and to coordinate the patient participation."	no	It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting compensation procedure and rules for experts participating in a JSC and/or JCA
Dr. Martin Danner BAG SELBSTHILFE	7	160	For patient it is often very intimidating, to get involved in HTA-processes. The quality of their input depends in general on their understanding of the reason why they get involved. Therefore after the recruitment it is necessary that a patient involvement team	no	We acknowledge the process is resource intense on both sides. In the future a structure

Germany			(see line 462!) coaches and supports the patients during their mission. Suggestion. Delete “on an ad-hoc basis”		should be put in place to support experts throughout their involvement (starting with the recruiting process)
Dr. Martin Danner BAG SELBSTHILFE Germany	7	162	The involvement of experts should not only be focussed on a passive vole role “respond” but it should be welcome if they give hints from their perspective Suggestions. Add “and give hints from their perspective” after “production”	no	Thank you. We amended the sentence.
Dr. Martin Danner BAG SELBSTHILFE Germany	7	170	The financial compensation is mandatory because the participation is the performance of a public task Suggestion: Replace “may” by “have to”	no	It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting compensation procedure and rules for experts participating in a JSC and/or JCA. Furthermore, not every expert may be able to accept compensation (e.g. due to national laws).
Dr. Martin Danner BAG SELBSTHILFE Germany	7	182	There is a hierarchy of expressiveness between patients with collective experiential knowledge, patients with individual experiential knowledge, proxies with collective knowledge, proxies with individual knowledge and patients’ representatives. The goal is to involve always persons which guarantee the best level of expressiveness which is available Suggestions: This methodical principle should be prefixed in line 182	no	This is explained in the paragraphs below

Dr. Martin Danner BAG SELBSTHILFE Germany	8	213	Sometimes a patient which is involved in the process has the impression that someone else knows better. In these cases the confidentiality agreement excludes the communication with other patients. Therefore, there should be a way to give such a hint so that someone else can brought into the process or to consult another individual. This is also a reason why patient experts should not be limited to answer questions. Suggestion: Add "If there is a need to bring in or to consult another expert, this can be indicated"	no	Unfortunately, this does not align with the definition of confidentiality used in our deliverable.
Dr. Martin Danner BAG SELBSTHILFE Germany	9	247-257	The anticipatory recruitment of patient experts has to be organized in advance for there has to be enough time between the recruitment and the mission to implement a sufficient coaching by the patient involvement team. Therefore an accreditation procedure should be introduced, to check COI, to check the level of experiential knowledge and the need of being coached by the patient involvement team. Suggestion: Add in line 246 "An accreditation procedure should be introduced to onboard patient experts. Suggestions for accreditation may be made by stakeholder patient organisations. Suggestions may be sparked by a public call for involvement". The recruitment of stakeholder patient organisations has to be structured by an accreditation procedure. The criteria named in the glossary (line 539) must be checked, but it must be pointed out that patient organisations have to be patient-driven, not only patient-focussed. Suggestion: Add in line 247 after "Approach" "as part of an accreditation procedure" and alter "organizations" "which meet the criteria of patient-driven patient organizations	no	This is related to the general Stakeholder network under the HTAR, and does not seem appropriate for the stakeholder and expert database/selection for involvement in specific JSC and JCA. The database described in this guidance (section 4.1.2) is open to any external expert willing to participate in a JSC/JCA. External experts can then be selected from the database, based on the needs for the specific JSC/JCA and e.g. based on the external experts expertise - please see section 4.2.1 where this is detailed. The final document will detail

					more specific selection criteria.
Dr. Martin Danner BAG SELBSTHILFE Germany	10	269	Patient organizations play an important multiplier role to explain the idea of HTA and to explain the procedures of the European HTA-process. They can even initiate an exchange of experiences between their members about the current treatments, the burdens of side effects in the field of a specific HTA-procedure. Suggestions: Add "Patient organization also play an important multiplier role to inform about HTA and possibilities to engage in HTA processes."	no	Thank you for the helpful suggestion, we outline this in the section on purpose/value for stakeholder involvement.
Dr. Martin Danner BAG SELBSTHILFE Germany	10	275	For many years the patient involvement team at the federal joint committee in Germany implemented a database for patient experts which is connected with the accreditation procedure for patient experts. Suggestion: To interview the patient involvement team and to use the database.	no	The database suggested in the guidance document is not intended to replace any national databases. Due to GDPR, we are not able to use any national database for EU purposes.
Dr. Martin Danner BAG SELBSTHILFE Germany	10	278	Part of the accreditation procedure should also be a check of -Conflicts of interests -The level of the (collective) knowledge of experiences -The need of being coached for the involvement Suggestion: Add after "area(s) of interest" "information on possible conflicts of interests, information on the knowledge of (collective) experiences, information on the need of being coached for the involvement"	no	This is related to the general Stakeholder network under the HTAR, and does not seem appropriate for the stakeholder and expert database/selection for involvement in specific JSC and JCA. The database described in this guidance (section 4.1.2) is open to any external expert willing to participate in a

					JSC/JCA. External experts can then be selected from the database, based on the needs for the specific JSC/JCA and e.g. based on the external experts expertise - please see section 4.2.1 where this is detailed
Dr. Martin Danner BAG SELBSTHILFE Germany	11	360	Normally the approval procedure at the EMA are known by the Stakeholders. Therefore, it should not be problematic to inform about the tested drug (medical products) and the comparator. Suggestion: Add after “indications” “and the tested drug /medical product and the comparator(s)”.	no	While the information might be publically available, we decide not to share this information as we do not want to ask the stakeholders about their opinions or experience with the treatment or comparators under assessment.
Dr. Martin Danner BAG SELBSTHILFE Germany	13	384	The input of national patient organisations can be very helpful to support the development of the consolidated PICO’s Suggestion: Add “National” in the field “online submission during scoping process” and as a “method” “Online meetings of European and national patient organizations to discuss the consolidation of PICO’S.”	no	The contribution of the national experts should be included in the individual position. But the process for national involvement is out of scope for this deliverable. This is clarified in the text.

Dr. Martin Danner BAG SELBSTHILFE Germany	14	384 (Draft JCA Report)	Patients experts should not be limited to answering questions but should also be allowed to comment on and to support the judgement of study designs and study results. Suggestion: Delete “ad-hoc questions” and “if necessary” in the line “Draft JCA report”	no	Thank you the sentence was amended.
Dr. Martin Danner BAG SELBSTHILFE Germany	14	385 (Between Approach 2 and Approach 3)	Between approach 2 and approach 3 of the JSC there should be organised a meeting of the national and the European patient experts to coordinate the input for the draft of issues Suggestion: Add “Meeting national and European patient experts to coordinate the input for the draft of issues.”	no	The contribution of the national experts should be included in the individual position. Unlike the involvement of European experts, the position of individual national experts is not presented in the JCA report or in the final written recommendation.
Dr. Martin Danner BAG SELBSTHILFE Germany	16	393	Scoping process: Also, national patient experts should be involved in the process of the consolidation of the PICO’s Suggestion: Add “national and European patient expert input” after “clinical expert input” “EU Assessment phase”: the involvement has to be prepared (coaching) and cannot be spontaneous. Suggestion: Replace the sentence of the first bullet point by -“Technical talk between (co-)assessor and national and European experts”.	no	The contribution of the national experts is expected to be included in the individual position. However, national expert input will follow national procedures and will not be documented in the EU JSC/JCA report, as it is not considered part of the HTAR mandate.
Dr. Martin Danner BAG SELBSTHILFE Germany	17	418	The aim of patient involvement is much broader. Patients can be helpful in defining relevant subpopulations, relevant comparators, accounting the data of different outcomes (preferences) and in judging the study designs Suggestion: Add standard sentences for all these aims.	no	Thank you for your comment. We will consider this feedback when finalising the guidance

Dr. Martin Danner BAG SELBSTHILFE Germany	20	442	The project manager should have an education in the methods of patient involvement Suggestion: Add after “European level” “The Project Manger has the knowledge of the common methods of patient involvement in HTA”	no	This will be recommended for the future
Dr. Martin Danner BAG SELBSTHILFE Germany	21	492	EU has the duty to provide barrier-free digital communication Suggestion: Add after “assessor” “and that all the digital communication in JSC and JCA is barrier-free”.	no	Thank you for this suggestion, we will add a recommendation on document accessibility.
Dr. Martin Danner BAG SELBSTHILFE Germany	21	503	Not only the geographical spread is important but also the difference in living conditions (employed or not, single or unmarried and gender / age) Suggestion: Add after “eastern European” “the recruitment of patient experts should consider the difference of living conditions, gender and age for these circumstances can be relevant for the PICO’s”	no	Since we are aiming to involve experts with collective knowledge, that can represent a community broader than their member state, we have taken out the selection criteria on geographical spread.
Dr. Martin Danner BAG SELBSTHILFE Germany	26	539	Patient associations have to be patient driven, not only patient focussed Suggestion: Replace “focussed” by “driven” Comment: Most of the definitions of the glossary are not necessary because they are not used in the guidance.	no	The definition included in the glossary is that of the EMA. We prefer not to make changes to another organisation's definition.
Bayer I. Stoeckert	general	N/A	The draft includes detials on “confidentiality” and “compensation”, both aspects are very critical parameter to define.		Thank you.
Bayer S. Caruso	general	N/A	The HTD should have the possibility to comment in the scoping process (JCA) as well as the stakeholders, as it helps to clarify any uncertainty and secures that the clinical studies and the following dossier are answering the demanded PICO(S) research questions.		This comment is outside the scope of the guideline, and is addressed in D4.2 (scoping process).

Bayer S. Caruso	general	N/A	The Guidance for the interaction with third-party representatives is differentiating the involvement between JSC and JCA, excluding stakeholder groups of patients or healthcare professionals from the process of JSC due to confidentiality reasons. This seems incomprehensible since the involvement in the JCA takes place under confidentiality as well until the publication of the final assessment report. Furthermore, excluding stakeholder groups might carry a risk of bias to the process of JSC, if only individuals are involved that come from a preselected stakeholder network.		It is not envisioned that stakeholders get access to confidential information, also not in the JCA. However, at time of a JCA more information is publically available, thereby allowing to involve stakeholders via an online questionnaire. The fact that a JCA is taking place is not confidential, but the fact that the HTD is receiving a JSC is confidential.
Bayer B Cuffel	Page 7	Footnote 2	The policy on managing conflict has the potential to exclude the necessary and relevant clinical and scientific experts required for JSC and JCA as described in the Procedural Guidance for Handling Declaration of Interest and in particular the 8 criteria referenced in section “4.1 Major Conflict”. In particular, criteria 4 is both unspecific and pertains to any scientific association funded by industry. As such, there is no request for a direct content link between the scientific areas covered by the association & the area the sponsoring industry partners work in and the topic the expert will be working on for the HTA In addition, criteria 8 excludes clinical and scientific experts active in the Scientific Advice Working Party where overlap on JSC and early scientific advice would side would be desirable and considering the conflict of interest requirements of EMA. Finally, the criteria for managing conflict of interest may benefit from harmonization with that from EMA which enables clinical and scientific experts in certain roles who have had recent (< 3 years) but no current major conflicts of interest at least in non-leadership, non-voting roles.		Thank you for your comment. This is outside scope of our document, as we follow the guidance for handling COI. It is up to the HTAR Coordination Group to decide how COI will be managed in the future and whether it should be harmonised with the EMA guidelines.
Dr Daniel	8	196	The definition of clinical expert as having experience in clinical research or		Thank you. We will look

Widmer UEMO			practice is good for General Practice. The WONCA - Europe give a definition of expertise/competencies of GPs: https://www.woncaeurope.org/page/definition-of-general-practice-family-medicine that can be used for the choice of competent experts.		at the link provided and see if any modification needs to be made to the definition in the document.
Dr Daniel Widmer UEMO	8	201-203	*"If a clinical expert is a member of a healthcare professional organisation or a clinical and learned society, the JSC 202 or JCA team should be informed of this role."* For GPs it can be the case. UEMO is the stakeholder organisation and WONCA is the academic society where experts can be choosen. Interactions are frequent between both societies.		Thank you for clarifying
Dr Daniel Widmer UEMO	9	258-259	"*Identified organisations/stakeholders may be able to assist in identifying external experts for a JSC or JCA."* UEMO can do this, by contacts with WONCA.		Thank you for this offer
Dr Daniel Widmer UEMO	10	263-269	Not clear: you mean participation of HTA bodies in medical congress about specific topics or the participation of some stakeholders or experts to HTA congress or conferences?		We have clarified the text on this statement
Ancel·la Santos, on behalf of BEUC	7 (Guidance)	177-178/2.2	**Comment:** The line should include a reference to consumer organisations, which represent the interests of citizens as users of healthcare services and goods, in line with the description made in page 28 of the document. **Proposed change**: ''(…) patient and **healthcare consumer** representatives (including family and carers), patient advocates and patient and **consumer** organisations''	X	This comment is out of scope of our current document.
Ancel·la Santos, on behalf of BEUC	7 (Guidance)	179-181/2.2.	**Comment:** It is not clear if the guidance uses here the term 'patient' and 'patient organisation' as an overarching term that includes consumer representatives and organisations as well. Please see our previous comment		Thank you for your comment. The definition of consumers

			and proposed change.		is included in the glossary appendix. Within EUnetHTA 21, most of the guidance has been developed with patients and HCP in mind. We acknowledge the role of consumers as stakeholders. It is up to the HTAR Coordination Group to consider the role of consumer organisations as stakeholders in the involvement in JSC and JCA.
Ancel·la Santos, on behalf of BEUC	8 (Guidance)	192-193/2.2.	**Comment:** For transparency purposes, and to understand better if patient experts represent their views or also that of an organisation, it should be specified on which capacity they intervene (as an individual expert and/or as the representative of a patient/consumer organisation). **Proposed change: ‘**’(…) In JCA, patients can also provide input as stakeholders representing the interests of their patient’s association. **When they represent the interests of an organisation rather than giving input in their personal capacity as an expert this should be specified’’**	X	Thank you. In JCA, patient organisations can participate as stakeholders via the online questionnaire. External experts are expected to provide experience (on a collective level), but should not express positions on behalf of an organisation
Ancel·la Santos, on behalf of BEUC	8 (Guidance)	224-226/3.2	**Comments:** As mentioned on line 234 of the document, major COI should be avoided. This principle should be reflected in the previous paragraph when addressing the reporting of actions that have been taken following the declaration of a COI. **Proposed change:** ‘’Under the HTA Regulation, declarations from external	X	Thank you for your suggestion. In the JSC and JCA report, there will be a disclaimer stating all individuals who participated in the

			experts and any actions taken as a result shall be recorded in the summary minutes of meetings and in the outcome documents of the joint work in question (Art.5). **In line with EUnetHTA 21 policy on the handling of DOI, such actions should include exclusions from a given task whenever there is a major conflict. These decisions should also be recorded.** (….)"		JSC or JCA are free of a COI. We do not wish to list who was excluded, because exclusion means they never took part in the activity
Ancel·la Santos, BEUC	9 (Guidance)	237-239/3.2	**Comment:** This paragraph should mention that submissions, including information on the organisation's funding, will be public.	X	Thank you. The text has been clarified.
Ancel·la Santos, BEUC	9 (Guidance)	260-262/4.1	**Comment:** In relation to the confidentiality of joint scientific consultations, at least EUnetHTA21 and the Coordination Committee team set up by the HTAR should be able to publish some details on the types of products that are under consultation. The EMA for example publishes the list of products granted access to the PRIME scheme and some other basic information such as the therapeutic area and type of data supporting the request (here)		Thank you for your suggestion. The Coordination Group will have to decide what information can be published in the future, but EUnetHTA 21 will consider publishing a general statement on how many JSC have been accepted/refused, and the domain classification (e.g. orphan, ATMP, oncology).
Ancel·la Santos, BEUC	10 (Guidance)	267-269 and 471-472 in sections 4.1.1 and 7	**Comment:** Training opportunities for patients on HTA engagement are welcome.		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance, EUnetTHA 21 participates in EMA training. Additionally,

					the recommendation will be expanded so that in the future it can be considered to develop specific training (online modules or dedicated training meetings) for EU HTA processes
Ancel·la Santos, BEUC	16 (Guidance)	401-403/5.2	**Comments:** We think that for transparency purposes, it is important that clinical experts who comment on a JCA report are named. They should be informed beforehand that this is a condition for participation.		Clinical experts have the choice to be named if they wish. Even if they do not wish to be named, a description of the expert will be included (e.g., medical doctor in X specialty)
Ancel·la Santos, BEUC	13 (Guidance)	Table 4.1/4.4	**Comment:** When seeking input from individual patients in JCA or JSA, it would be better to give them the questions beforehand and the opportunity to reply in writing as this will give them some time to prepare their answers. This could be then followed by an interview. In addition, when providing briefing packages in JSC it would be important to highlight the information that is most relevant to the patient, to help them navigate the documents. Moreover, patients/consumers need to be offered some support in these processes as they might not be familiar with neither the technical aspects of drug development and evaluation, nor with the language used in these documents (e.g., 'endpoint', 'phase II trial', 'surrogate', etc).		Thank you. The document will specify that the interview guide will be shared prior to the interview. However, we do not want to burden the individual expert by requesting a written statement. Should the expert wish to provide it in written, the expert will be given that opportunity. We agree with the comment you made regarding support for the patient throughout

					the process and help them understand/navigate the documents received.
Ancel·la Santos, BEUC	19 (Guidance)	422-423/5.3	**Comment:** We support very much that feedback is sought at the end of the stakeholder or expert involvement in a JSA or JCA in the form of a questionnaire. In addition, they should be updated about the outcome of a JCA they contributed to and on how their feedback was considered by the assessors. Ideally, this should apply as well to a JSA.		Thank you for your comment. This will be taken into account as procedures for JSC and JCA are finalised.
Ancel·la Santos, BEUC	21 (Guidance)	501-503/7.1	**Comment:** We agree with aiming at ensuring a good geographical spread when consulting patients and consumers in JSA and JCA.		Thank you.
CPE	6 7	1.1 2.1 Ln	It is essential to state a clear goal for the patients involvement. HTAi's Values and Standards for Patient Involvement in HTA (2014)https://htai.org/patient-and-citizen- involvement/ state that 'patients have knowledge, perspectives and experiences that are unique and contribute to essential evidence for HTA'. For this reason, the document should contain: - A clear and distinct statement of goal(s) or aim(s) for involving patients in JSC and JCA which articulates the value of lived experience as a source of expertise and a unique contribution that can be made by patients and their representatives such as carers and staff/volunteers of patient associations. Patients and their advocates involvement should not be blended with the aims of involving health professionals who bring a different expertise. - A clear framework setting out the who, when, where and how (methods and approaches) guided by the goals to increase the likelihood of patients involvement to be meaningful. We recommend INAHTA's position statement on patient involvement (2021) as a useful guide. Note also HTAi's quality standards for general HTA processes, especially the need for reflection and review to allow continuous improvement. Financial compensation: The statement: "financial support for their participation is not expected, as the incentive to get involved is to promote the position of one's own organisation" is not correct. The sole interest of patients to be involved in the HTA process is to protect the interest of other patients, not to promote the position of the ssociation they belong to. Thus, especially when the patients or their representatives are volunteers within the association		Thank you. We adapted the text and refer to the different initiatives in a concise manner

			and not employed by the association, their effort to participate in the HTA process must be paid and their live expenses reimbursed. Otherwise, a barrier is created to an equal access even within the HTA process itself. This is also stated in the PARADIGM (2021) guiding principle #8 Financial Compensation and Reimbursement of Expenses: "Patient advocates deserve a reasonable financial compensation for their time and contribution when acting in advisory roles, consultancy, speaking roles or other collaborative work with third-party organisations or institutions." The rationale to prefer individual patients to patient representatives or patient advocates is not clear, especially in the JCA. A framework with clearly defined roles and criteria might help to clarify this point. Currently, it is unclear why the ability of patient associations to bring a broad range of knowledge and experiences to the JCA would be limited to written submissions which do not allow for the dynamism of the discussion in the committee. We note the definitions and suggest also considering Street J, Stafinski T, Lopes E, Menon D (2020). Defining the role of the public in Health Technology Assessment (HTA) and HTA-informed decisionmaking processes. International Journal of Technology Assessment in Health Care 1–9. https://doi.org/10.1017/S0266462320000094. This sentence puts the pressure on patients to acquire scientific knowledge to participate. This expectation from HTA bodies may be a barrier to participation and will not help HTA researchers to incorporate experiential knowledge by making non-scientific voices less legitimate and therefore, less heard.		
CPE	10 13	3.1, ln 207 4.1.2 Line 288 Table 4-1	HTA researchers could profit more from another approach. Our suggestion: "Facilitations skills and training in participatory methods can help those who conduct EUnetHTA 21 JSC and JCA to make the process more fruitful and efficient" It is essential that patient experts and their associations taking part in JSC and JCA receive appropriate information to support their effective contribution. Developers should submit a Plain Language Summary or Summary of Information for Patients which can be checked to ensure content is accurate and non-promotional, then handed to the external patients and experts as a base line information in addition to the specific information from the overall package. This will be essential to receive a qualified input from the patients. What measures will be taken to ensure that this registration is accessible to all to promote fair access to the HTA process? Currently the promotion of the registrations is limited to those already connected to EUnetHTA. HTAi's Values and Quality Standards state that 'patient involvement processes address barriers to involving patients in HTA and build		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance, EUnetTHA 21 participates in EMA training. Additionally, the recommendation will be expanded so that in the future it can be considered to develop specific

			capacity for patients and HTA organizations to work together. In the stage of transition, it should be possible to contact the people in the EUnetHTA21 database and motivate them to register in the future database / registry. (1) Before being involved, patients and patient experts need to be informed on the aims of the patient involvement for their specific involvement and this information should be aligned and clear for all stakeholders. (2) They should also know what type of patient / clinical stakeholders are involved for what purpose; potentially, how the input is intended to be used / implemented.		training (online modules or dedicated training meetings) for EU HTA processes The current EUnetHTA 21 stakeholder repository is not set up in a way to suit the needs of an expert database for a JSC and JCA. Additionally, EUnetHTA 21 will not have resources to set up a dedicated external database for this purpose
CPE	16	5.1.2	3) They should get an overview (simple) on the respective HTA process and where in the process their contribution will play a role Joint Clinical Assessment (JCA): What kind of information will be taken into account and how? Will there be a consultation of the report, where patient experts / stakeholders can react? Page 16; 5.1.2 JCA / EU Assessment phase: Patient experts should be standard not ad hoc. Their consultation on the draft report should be included.		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance, EUnetTHA 21 participates in EMA training. Additionally, the recommendation will be expanded so that in the future it can be considered to develop specific training (online modules or dedicated training meetings) for EU HTA processes.

					For JSC expert(s) involved will be part of the review process. For JCA no consultation process is foreseen. Both procedures will do an evaluation process after the involvement
Mihai Rotaru - EFPIA	General		EFPIA welcomes the publication of this Guidance. We acknowledge the progresses achieved by this document concerning the involvement of patients and HCPs in the HTA joint work compared to the past. EFPIA would also like to point out some outstanding issues that might be worth receiving further consideration in the scope of this document (some of which are addressed by specific comments, when possible). In that sense, we tend to consider the present document as a preliminary work that needs further development. In addition, EFPIA would welcome a clarification on the applicability of this Guidance, which seems to be shaped for the purpose of the EUnetHTA21 JSC/JCA Pilots, rather than to inform the new system under the HTAR. - The distinction between “stakeholders” and “experts” The distinction of patient and healthcare professionals in “stakeholders” and “individual experts” should be clarified and possibly improved. EFPIA noticed that the status under the label of stakeholders severely limits the involvement of patient and healthcare professional organisations and of their representatives. As a result, such an approach would also limit the options for the assessors to catch the most adequate input when need be, especially in JCA. For example, where the assessors would need to know the view of a patient community or a medical society, per the current guidance, they would be limited		Thank you - it appears all of these comments have been mentioned in your comments below and we have responded there.

			in their options to an indirect interaction only (via questionnaires). Therefore, if such a need arose at a later stage in JCA, there should be the possibility to consult a representative of a medical society or of a patient organisation. Furthermore, we wish to highlight that the possible affiliation of patients or healthcare professionals to a patient network/organisation, or to a learned or medical society, should be considered as an important contributor to their expertise (in addition to training and experience) as medical knowledge increases at a fast pace. Finally, we consider that multiple options of interaction/involvement (in accordance with the rules on confidentiality and CoI, and with the possible need for input) should be considered or at least not excluded. We suggest improving the frame of these definitions in order not to preclude such an option. Based on EFPIA experience, patients and healthcare professionals may be involved: •In collaboration with the assessment team in disseminating the request for input and/or identifying suitable experts/representatives (via a point of contact, under clear confidentiality and CoI rules) •As groups (indirect involvement by questionnaires or written submission, via a point of contact, under clear confidentiality and CoI rules) •By involving their representative(s) as experts in the assessment process on behalf of their organisation •As individual experts (in their own capacity) Points on which we consider further clarity is needed: (a) Procedure The actual procedure for involvement should be improved by establishing a point of contact within patient and HCP organisations (with their right and obligations with respect to confidentiality and CoI) (b) Selection		

			The methodology and scope for the selection of patient and healthcare professional representatives (on behalf of their organisations, or as individual experts) should also be addressed and codified. Clear accountability should be foreseen for the decision over the experts/representatives selection (i.e. who decides: the patient/HCP organisation or the assessors?) (c) Level of involvement The level of involvement (as already mentioned) should be improved by allowing the participation of patient and healthcare professional organisations' representatives, and also clarified for JCA procedure, by providing the level of information that will be shared in different approaches. (d) Confidentiality Together with the involvement of experts and stakeholders, there are commercially sensitive information that might be needed to be shared for the purpose of JSC or JCA (indication only). This information must be clearly defined, avoiding any disclosure that might harm the HTD's development plans or regulatory/HTA submissions. In both JSC and JCA, the HTD should be kept informed in a systematic way on whose experts are becoming entitled to access such information and what information would be disclosed. All experts and stakeholders involved should be submitted to clear rules for confidentiality, which should be clearly outlined in the Guidance. (See further comments) (e) Assessment of Conflict of Interest EFPIA considers that - when involving patient and HCP as individual experts or as representatives of their organisations - there is strong need for clear rules to evaluate the acceptable level of conflict (if any) against the need for the specific expertise required for the JCA or the JSC (e.g. patient that participated in clinical trials or clinical investigators for JAC). In that sense, we consider that the affiliation of patients and healthcare professionals to an organisation or a learning society must be considered, when appropriate, as a significant contributor to their expertise. In view of the development of D7.5, we would like to recommend EUnetHTA 21 build on what has been outlined in EUnetHTA JA3 (Cf *Procedure Guidance for*		

			handling Declaration of Interest (DOI) and Confidentiality Agreement forms) Finally, we consider that fulfilling these points would be even more essential in view of the future model of cooperation under the HTAR. The future Stakeholder Network established by HTAR (Art 29, not covered by this Guidance) may not immediately gather all the potential organisations the CG/Sub-group may need to interact with, especially at the beginning.		
Mihai Rotaru - EFPIA	7	151-152	"The involvement of stakeholders in the work of the Stakeholder Network is outside the scope of this deliverable" EFPIA understands that EUnetHTA21 rightfully intends not to interfere with the formal implementation of the Stakeholder Network (Art 29), which is the responsibility of the European Commission. Nonetheless, as per general comment, EFPIA considers that as far as this Guidance aims at defining the models of interaction of patients and HCPs with assessors and HTA organisations (future CG/Sub-groups), especially for a transparent process for the identification of external experts and representatives, this Guidance may also inform some aspects of the work of the future Stakeholder Network. We therefore suggest clarifying this point, by editing this statement as follows: "*The creation and establishment of the Stakeholder Network as foreseen by HTAR (Art 29) is the exclusive responsibility of the European Commission and is outside the scope of this Guidance*". We also recommend the inclusion in Chapter 7 of a specific recommendation, highlighting the need in the future model of cooperation for a framework of interaction (that may correspond to the Stakeholder Network or being wider than that).		The text has been clarified regarding the stakeholder network under HTAR Art. 29. Since it is out of scope for this guidance, we have not added a recommendation on this.
Mihai Rotaru - EFPIA	7	154-156	*"A Declaration of Interest (DOI) form is not required for stakeholders as they are considered to have an inherent conflict"* For the purpose of this Guidance, which is focused on patients and healthcare		Thank you for the suggestion. The document has been amended.

			professionals, we consider this statement highly controversial and potentially misleading. *1) About "inherent conflict"* It seems to implicitly suggest that the aim and mission of patient organisations and learning-medical societies might be in conflict with the purpose of HTA, without even mentioning or precising what such conflict might consist of. Based on EFPIA's knowledge of patient and health professional organisations, we would reject such a statement, reminding their role in the evaluation of medicines acknowledged by all EU pharmaceutical legislations and the role they have been playing in cooperating with the European Medicines Agency: -https://www.ema.europa.eu/en/partners-networks/patients-consumers; -https://www.ema.europa.eu/en/partners-networks/healthcare-professionals) *2) About DoI, funding, and financial compensation* Further clarity is needed in the part that deals with Declaration of Interest (DoI) and funding. EFPIA's understanding is that a DoI applies to individuals and not to entities like organisations, which should instead disclose their sources of funding. However, there are scenarios when the involvement of an individual as representative of an organisation would require further specifications (for example: both DoI and organisation's source of funding) The same need for clarification applies to the financial compensation of patient and HCP organisation representatives whenever they might be involved in person (see next comment) We suggest editing as follows: "A Declaration of Interest (DOI) form is not required for *organisations* ***as this applies to individual experts and representatives, and is intended to disclose their (and potential) situations of conflict***. ***Organisations and their representatives*** are required to provide information on the funding ***(public and private)*** of their organisations as part of any other stakeholder submission".		

			In addition, EFPIA regrets that as of today EUnetHTA21 have not considered to establish a dialogue with relevant and concerned stakeholders on the D7.5 (Guidance on CoI), even by excluding it from its public consultation plan.		
Mihai Rotaru - EFPIA	7	156-157	"*Furthermore, financial support for their participation is not expected, as the incentive to get involved is to promote the position of one's own organisation"* The *same* need for clarification applies to the financial compensation of patient and healthcare professional organisation representatives whenever they might be involved in person. EFPIA understands that financial support to stakeholder organisations is not within the remit of EUnetHTA21 or HTA bodies, as financial support directed to organisations raises numerous technical problems and issues. However, we consider this statement highly controversial and misleading 1) The primary objective of patient organisations that participate in HTA is not to promote a specific advocacy position, but to enable the participation of patients in deliberations and evaluations of treatments that affect their lives, and, in so doing, ensuring high quality HTA. 2) This statement might be misleading with regard to the overall issue of how to make the effort of patient and professional organisations in the joint work sustainable and effective (e.g. effort in staff and time-resources to review documents such as the work plan and annual report, replying to consultations, identifying patients, and delivering training programmes). Such issues should be carefully considered in the Future Model of Cooperation and brought to the attention of the European Commission (via a specific recommendation in Chapter 7). We suggest editing: "Furthermore, financial support for their participation is not expected ***as it falls out of the EUnetHTA21 legal framework and remit. The challenges related to the sustainability of the involvement of patients and healthcare***		We have clarified the text, thank you for your suggestion

			professionals as stakeholders in the European HTA work is within the remit of European Commission and should be addressed in the context of the implementation of HTAR".		
Mihai Rotaru - EFPIA	7	182-185	With regard to the wording: *"patients with collective experiential knowledge".* Although we do not consider this wording as formally "incorrect", we suggest improving it by including some elements of clarity. In particular, we consider it would be worth to refer to "patient as representatives of patient networks or organisations". We consider affiliation to a network of peers as the key element of that knowledge mentioned in the text, which should be considered as an important contributor to their expertise.		Thank you for your comment. The definitions of both stakeholders and experts have been clarified.
Mihai Rotaru - EFPIA	7	187-188	EFPIA considers that there should be adequate resources and capacity allocated to systematic training of patients/HCPs who will be involved in JSC/JCA procedures to ensure they can timely and appropriately contribute to the joint work. Particularly for JSCs, training is often important to ensure that the experts involved understand their role, commitment to timelines and the process, confidentiality of the materials that they will access. Developers consider it critically important that anyone accessing even any parts of the briefing book has a good understanding of its nature and strict confidentiality of the information. It should be noted that many experts and stakeholders may not regularly interact in such processes and it is important that they have a foundational understanding of the process and its intentions.		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance, EUnetTHA 21 participates in EMA training. Additionally, the recommendation will be expanded so that in the future it can be considered to develop specific training (online modules or dedicated training meetings) for EU HTA processes
Mihai Rotaru - EFPIA	8	204	*"In JCA, healthcare professionals can also provide input as stakeholders, representing the interests of their organisation (e.g. clinical society)"*		Thank you, this has been modified.

			As per previous comments, we consider the participation of a healthcare professional society in JCA a requirement for a high quality assessment, by the sharing of their collective knowledge, expertise and experience via their representatives. We therefore suggest substituting the wording *"representing the interests"*, with to following: *"sharing the views"*.		
Mihai Rotaru - EFPIA	8	207-209	*"External experts may receive access to certain documents (such as draft JCA report, submission dossier, JSC briefing package (whole or part of it) etc.) according to the needs of the Assessor and Co-Assessor and according to the background of the expert"* When involving patients and healthcare professionals, EFPIA recommends to equally respect the right of the experts to access information that are relevant for their input and the right of the HTD to protect commercially in confidence information. Sharing of information must be kept to a minimum and regulated under the same rules of confidentiality that apply to the co-assessors. Moreover, the HTD should be informed on who has access to commercially confidential information.		Every individual expert participating in a JSC or JCA, can only participate in such activity after submitting a completed and signed a EUnetHTA 21 Confidentiality Agreement From. This form does not lead automatically to inclusion, as the form (as well as the Declaration of Interest form) needs to be approved by the Secretariat. With regard to the information to be shared, it is important experts have access to the entire information package as they can provide relevant feedback in areas that were not anticipated by the (co-)assessors.

Mihai Rotaru - EFPIA	8	214-218	Information on development programmes before the start of pivotal trials, as well as information on clinical study results, is extremely sensitive. Only the experts to which this is essential for their input should be granted access to it, under confidentiality undertaking, in order to avoid potential breaches of commercially confidential information. With regard to the JSC briefing book, the experts involved should preferably be allowed to focus only on the parts that are relevant for their input or that are addressed by the list of issues. The JSC final recommendation letter is a document destined for the HTD. Only the experts involved should be allowed to do an accuracy check (at the draft stage) on whether their input was correctly reported. With regard to the JCA documentation, the information included in the submission dossier and the draft report should remain confidential (including label/indication) at least until CHMP opinion. The experts involved should respect these same confidentiality rules.		Every individual expert participating in a JSC or JCA, can only participate in such activity after submitting a completed and signed a EUnetHTA 21 Confidentiality Agreement From. This form does not lead automatically to inclusion, as the form (as well as the Declaration of Interest form) needs to be approved by the Secretariat. With regard to the information to be shared, it is important experts have access to the entire information package as they can provide relevant feedback in areas that were not anticipated by the (co-)assessors.
Mihai Rotaru - EFPIA	8	217-218	*"Information or feedback regarding their experience of being involved in a JSC can be shared, but this must be done without revealing the content of the JSC"* EFPIA is concerned about this possibility not being precisely defined and recommends either removing this part or providing more clarity about the kind of feedback the participants would be allowed to share. For instance, we suggest only feedback on practical aspects that are meant to		Thank you for this comment. The intent was to say that they could, for instance provide feedback in a training session to explain what happens

			improve the process being allowed (e.g. recruitment steps, time to prepare the meeting, difficulties in understanding the questions).		when one participates in a JSC, but that the discussion must be limited to only the process itself, not any discussion about the company, product, who participated. In the spirit of allowing this kind of information to train others, we would like to leave this but we can make this more explicit in the guidance.
Mihai Rotaru - EFPIA	8	229	EFPIA wishes to highlight that different approaches apply when assessing possible conflicting interests at national or at European level. This might lead to inequalities in the involvement among patients or healthcare professionals based on the country.		We acknowledge the difference in COI practices across Europe. The document has been modified to clarify that national involvement will remain on the national level. Only European-level involvement will be reflected in the final Recommendations (JSC) or Report (JCA).
Mihai Rotaru - EFPIA	9	237-239	*"Patients and healthcare professionals that contribute as stakeholders to a JCA are required to provide information regarding their organisation's funding within their submission*, via the respective input template" As per previous comment, we consider, here again, that the participation of patients and healthcare professionals should not be limited to a unique model of (indirect) involvement. Different involvement options should be considered or at least not excluded (as mentioned in Table 4-1).		Thank you for your comment. Indeed different options for involvement are listed in Table 4-1 depending on the time point of involvement.

Mihai Rotaru - EFPIA	9	243	EFPIA suggests including the possibility for the HTD to submit patient or healthcare professional experts to the consideration of the project manager for JSC and JCA.		In case a public call is launched to identify external experts, the HTD is welcome to circulate this call. However, due to conflict of interest, we cannot accept external experts that are suggested by the HTD
Mihai Rotaru - EFPIA	9	247-262	EFPIA would recommend integrating the approach for recruitment of stakeholders and external experts with reference to relevant initiatives like EUPATI, PARADIGM, and other IMI/IHI or European Commission supported projects that involved patient experts.		We will look into their approaches for recruitment and see if modifications are necessary
Mihai Rotaru - EFPIA	9	243-262	About the "*Recruitment of Stakeholders and External Experts*" EFPIA considers it essential to provide a transparent and efficient recruitment and selection process of patients and healthcare professionals, both as individual experts and/or as representatives of their organisations.		A section has been added to clarify the selection process of external experts
Mihai Rotaru - EFPIA	9	254-255	EFPIA strongly recommends collaborating with the EMA and using their existing resources for the identification of experienced and trained patients and professionals for both JSC and JCA, as this will increase the efficiency and the quality of the recruitment. In addition, experts who are familiar with the process will increase the quality of the input.		Thank you, we agree with this comment and this already has been part of the guidance. However, it does not mean the same experts will be involved on both the regulatory and HTA side.
Mihai Rotaru - EFPIA	9	258-262	EFPIA's view is that the involvement of patient and healthcare professional organisations starts with the identification of experts and representatives for the joint work. The knowledge of the networks and the trust of their members is a key resource that those organisations have, which should be systematically used to identify experts and representatives.		Text has been clarified that patient organisations and medical societies can help identify relevant

			Furthermore, the recruitment of patients and clinicians requires also clear and expertise-based criteria for their selection. EFPIA considers it is therefore important to outline such criteria, which (together with training and experience) might include the affiliation to a patient/clinician network as an important piece of expertise. In that sense, EFPIA recommend considering the establishment of points of contact within patients and healthcare professional organisations, who should be subjected to confidentiality undertaking with regard to sensitive commercial information.		external experts. Further, a section on selection criteria has been added. When reaching out to organisations for support in identifying external experts, the Secretariat will not share any confidential information. Therefore, it is not foreseen to establish confidentiality undertakings with those organisations.
Mihai Rotaru - EFPIA	9	260-262	*"For JCA, external experts and stakeholders can also be recruited through a public call for involvement on the EUnetHTA 21 website and social media channels. For JSC this is not possible, as JSCs are confidential in nature".* As per previous comment, EFPIA considers that the involvement of patients and healthcare professionals in JCA may occur at different timepoints, in particular before marketing authorisation. For that reason, we require the authors to consider the need for clear rules to protect confidential information also for the involvement in JCA (at least until the moment of the CHMP opinion). As per previous comments, confidentiality should apply in the same terms to experts and representatives of organisations involved in any extent in the process.		It is not envisioned that stakeholders get access to confidential information, therefore we see no need to set up such process. At the time of a public call for recruitment, the information provided (e.g. disease area) will already be part of the public domain, for example because of EMA assessment or press release by the HTD.
Mihai Rotaru - EFPIA	11	333-334	"*Post-EUnetHTA 21 a more sustainable external expert database would need to be developed using a relational database system, which is scalable and could*		The current EUnetHTA 21 stakeholder

			be similar to what EMA is using" As per previous comments, EFPIA recommends that EUnetHTA21 and other HTA organisations work synergistically with EMA to achieve a single database system, which might avoid having duplication of repositories with similar data and save resources for maintenance. EMA, EUnetHTA, and HTA organizations' databases are resourced through the public sector and should therefore be subject to same privacy rules (GDPR).		repository is not set up in a way to suit the needs of an expert database for a JSC and JCA. Additionally, EUnetHTA 21 will not have resources to set up a dedicated external database for this purpose. The alignment with the EMA database is out of scope for this guidance and is for future decision under the HTAR CG and the EC.
Mihai Rotaru - EFPIA	11	341-344	We propose adding the following sentence to the paragraph: "Clear, accurate and timely information has to be provided to the HTD on how and when experts and stakeholders are involved in a JSC or JCA process."		Thank you for your comment. The procedures and timelines on involvement have been described.
Mihai Rotaru - EFPIA	11	357-365	**4.2.2 Stakeholder involvement** As already reported in previous comments, EFPIA wishes to highlight the need for further clarity and completeness. With regard to the overall definition of "stakeholder", this Guidance remains unclear about the possibility to involve representatives of patient and healthcare professional organisations in the JSC and JCA. Such option, once again, should be considered (and at least, not excluded, as mentioned in Table 4-1). Moreover, EFPIA expresses a fundamental concern over a possible exclusion of individuals (patients or clinicians) due to their affiliation to a patient group or a medical society (in JSC or JCA). EFPIA strongly call for avoiding such a		Thank you. The definition of both stakeholders and experts has been clarified. We also did not intend to give the impression that an expert would be excluded merely because they are a member of an organisation. We have clarified the section on

			"discrimination" among potential experts. An individual expert affiliated to an organisation, should receive the same consideration, based on its profile and expertise (as well as on clear and transparent rules on CoI).		recruitment and added a section on the selection process for experts.
Mihai Rotaru - EFPIA	12	372-373	*"Any information obtained through experts (for JCA and JCA) or stakeholder input (for JCA) is complementary information"* Please, replace with: *"Any information obtained through experts (for **JSC** and JCA)…"* As per previous comments, EFPIA also recommends considering the option of involving stakeholders also in JCA via their representatives. This might bring valuable input, as for instance in the choice of the comparator, which could also inform the PICO later on.	Yes	Thank you for your comment the typo has been corrected.
Mihai Rotaru - EFPIA	12	374-375	"The different products (JSC vs JCA) require input at different timepoints in the process and sometimes also different types of input (expert vs. stakeholder)." Overall, EFPIA is concerned on the lack of clarity in the language. Instead, we see a clear need for defining a predictable and standardize process for each deliverable, to avoid delays and inconsistencies.		Thank you, the ways to participate and the timing has been further clarified.
Mihai Rotaru - EFPIA	13-14		**Table 4.1 (General)** As per previous comments, we wish to highlight: •The involvement of patient and healthcare professional organisations is required from the stage of the request/call for involvement, either when disseminating a questionnaire or when identifying experts/representatives •Considering language improvement between the wording "stakeholder" and "representatives (of an organisations)" •Despite not being included in this table, we wish to remind the importance		Thank you for the comment. We have provided an answer to this in the earlier comments you made.

			of providing the necessary level of confidentiality to protect commercial sensitive information when those are shared for the purpose of the involvement (from the stage of the experts/representatives search/identification)		
Mihai Rotaru - EFPIA	14		• **Table 4.1 (JSC Approaches)** JSC discussions (mainly) focus on the product development plan. Patient and healthcare professional inputs in JSC (as experts or stakeholders) may encompass the following aspects (not exhaustive list): Clinical experts: • clinical trial and study feasibility; • inclusion and exclusion criteria; • comparators; • how meaningful improvement are defined and valued; • Identification of eligible patients in real-world clinical practice (vs study), • treatment patterns, • standard of care, • relevant guidelines, • unmet medical need, • settings of care Patient experts • patient-experience burden of disease & unmet need, • patient-relevant endpoints, • patient-relevant outcomes, • quality of life topics; • meaningful change, • study design (duration ..), • willingness to enrol in such a study. In that sense, we consider that the wording under the field “purpose” does not reflect such a variety. We therefore suggest improving the language in this field.		Significant adjustments to the approaches you mention in your comment have been made: the approach that is now left is the one for full involvement.

			Moreover, the HTD should be kept informed of the approaches used in collecting expert and stakeholder input. EFPIA also believes that the timepoint of involvement in JSCs in the proposed approaches 1 & 2 is too late (Cf. "prior to draft written recommendations"). We therefore suggest this step to come earlier, same as for approach 3 (i.e., prior to "draft List of Issues") *For JSC (approach 2/3 only).* With regard to the briefing book, patients and clinicians involved should preferably be allowed to focus only on the parts that are relevant for their input or that are addressed by the list of issues. On the other hand, the final recommendation letter is a document destined to the HTD. The experts involved should only be allowed to do an accuracy check (at the draft stage) on whether their input was correctly reported.		
Mihai Rotaru - EFPIA	15		**Figure 5-1 - time points of involvement in JSC process (under EUnetHTA 21 and HTA Regulation) – Approach 3** EFPIA welcomes the provision of this timeline. We also encourage that as much as possible, the recruitment of the experts and stakeholders take place during the briefing book development so that the process is not further delayed. It is important to find ways to shorten the current 9-month process. In that sense, we consider that more details on the actual process of involvement would be required. In particular, we refer to the following elements: •The kick-off of the involvement should be the notification of patient and healthcare professional networks/organizations, via an organization's point of contact (under confidentiality undertaking) •The kick-off should occur earlier, at the moment of the acceptance of the JSC request •Selection of the adequate experts'/representatives' profile: the criteria for the selection should be based on the required input and the level of expertise/knowledge		Thank you very much for your comment. We will take this feedback into account when finalising the guideline. Especially figure 5.1 will be adapted. Regarding the last point: We use the developed templates as a guideline. Of course, the experts are allowed to focus on topics they consider relevant and to formulate additional points they consider important.

			• It should be clarified who would be finally responsible for the selection of the experts/representatives (patient / HCP or HTA organisations?) • Are interviews and written contributions based on the List of Issues? (Please, specify) • (F2F Meeting) Where it is written: "experts are invited to give their input", we suggest editing: "invited to take part in the discussions" *For JSC (approach 2/3 only).* With regard to the briefing book, patients and clinicians involved should preferably be allowed to focus only on the parts that are relevant for their input or that are addressed by the list of issues. On the other hand, the final recommendation letter is a document destined to the HTD. The experts involved should only be allowed to do an accuracy check (at the draft stage) on whether their input was correctly reported. EFPIA wishes to highlight an inconsistency between Guidance 7.1 and the present Guidance 7.2. While D7.2 includes the participation of experts to the F2F meeting, D7.1 does not mention this scenario in the description of the same process (Cf. D7.1, p15)		
Mihai Rotaru - EFPIA	16		**Figure 5-2 – time points of involvement in JCA process (under EUnetHTA 21 and HTA Regulation)** Regarding the Scoping Process, EFPIA insists on drawing the attention of the authors on the following: • In EFPIA's view, the scoping process should enable a dialogue between all parties, including HTD, patients and healthcare professionals (Cf. our response to D5.2 consultation) • Need for clarity and language improvement about the involvement of "stakeholders vs experts" (both patients and healthcare professionals) • The possibility of involvement of patient and healthcare professional representatives in JSC should be included and not limited to an indirect interaction only (as questionnaires). In the current times, it is hard to consider a virtual meeting more difficult to be held than a questionnaire. • The confidentiality of commercial sensitive information that have to be shared with experts/representatives or organisations points of contacts		Thank you for your comment. We refer to the guidance and answers provided under D4.2 - scoping process. The figure already mentions the EU expert (patient/HCP) can participate in the PICO consolidation meeting. However, to facilitate the input given the limited time available for experts, we also allow for other options

			should be guaranteed also in JCA		such as interview or written statement.
Mihai Rotaru - EFPIA	16	399-403	With regard to JSC procedures, especially for approach 2 & 3, the HTD is entitled to know with whom confidential information are shared. Therefore, we require that all the names of the experts involved are disclosed in any form of reporting for JSC.		European participation of patients and clinical experts ideally follows approach 3. Therefore, it is aimed that patients and clinicians participate in the F2F meetings and that relevant information is communicated to them beforehand.
Mihai Rotaru - EFPIA	20	439-449	EFPIA notice that the Guidance indicates the project manager as responsible for all external communications as well as for the liaison between JSC/JCA assessors and co-assessors. We strongly recommend relying on a common Secretariat for all JSCs and JCAs procedure. We consider this would contribute to the consistency across the procedure and facilitate experience gain over time. Moreover, EFPIA would require more clarity on the involvement of stakeholders and experts at national level (including their expected number per procedure, the recruitment process, the accountable body for their selection, for the sharing of information, and for the collection of the input and reporting).		Thank you. We agree that the secretariat will play an important role under the future HTAR however the matter of the secretariat is described in the HTAR and is to be established by the EU Commission and therefore is outside of the scope of this deliverable.
Mihai Rotaru - EFPIA	20	456	It is recommended to prioritise the development of a process to involve methodological and other experts. This is particularly important with the developments within the regulatory space, e.g. with DARWIN EU, that will accelerate use of RWE as a part of the regulatory decision making. Moreover, engaging academic experts is also crucial, so as to increase the expertise in the system and avoid that the current methodologies hinder the introduction of new technological advancements.		This comment is out of scope of the current document, and will need to be considered by the HTAR Secretariat when setting up the Stakeholder Network

Mihai Rotaru - EFPIA	21	491	EFPIA encourages the inclusion of patients and healthcare professionals as experts regardless of their English-speaking ability. At the same time, the implementation of this solution requires that the necessary translation process would not delay the process.		Next to the EU level involvement that is described in this guidance, there are also possibilities to be involved on a national level (following national HTA body's rules and procedures), thereby not requiring knowledge of English. Section 7 of the guidance document addresses the issue of knowledge of English language in submitting input for a JSC or JCA on EU level.
Mihai Rotaru - EFPIA	21	502-503	For JSC and JCA taking place after EUnetHTA 21, as a minimum geographical spread should be targeted, e.g. trying to identify patient and clinical experts from southern, western, northern and eastern Europe. Although it is useful that a minimum geographical spread should be targeted, we like to draw attention to the specificities of certain conditions, such as rare diseases, having a very heterogeneous epidemiological distribution within the EU. Such specificities should be considered next to geographical distribution.		Since we are aiming to involve experts with collective knowledge, that can represent a community broader then their member state, we have taken out the selection criteria on geographical spread.
European Patients' Forum	general	general	The European Patients' Forum will make available more detailed comments at a later stage.		Thank you.
European Patients' Forum	6	119-122	Suggested rewording: Patients and healthcare professionals can provide input about the disease and insights into treatment processes. Their input can **inform the assessment team on the study design, including aspects such as the selection of relevant outcomes linked to the direct and indirect impact of the disease and** characterisation of the appropriate patient population. This can contribute to improve the relevance, legitimacy and	x	The section on general principles - value of patient/HCP involvement was revised.

			transparency of assessments and recommendations.		
European Patients' Forum	6	122	Suggested rewording: The input of healthcare professionals **and patients** can additionally support…	x	Thank you the section on general principles - value of patient/HCP involvement was revised.
European Patients' Forum	6	131-132	Comment: Stakeholders and expert profiles may overlap, meaning that a patient representative may also be a patient expert.		Thank you, we agree.
European Patients' Forum	7	154-155	Comment: Patient organisations as stakeholder representatives act in the interests of patients, just like assessors have the interest of supporting the HTA process. Suggested rewording: delete "as they are considered to have an inherent conflict"	x	Text has been changed
European Patients' Forum	7	156-157	Comment: Patient organisations' involvement is based on the need to promote the interests of patients, *not* a specific organisation. Therefore, financial support for these activities will be needed. Within a "patient organisation" there may be different profiles. Ensuring to always inform HTA based on the best available expertise requires internal coordination to identify the most appropriate profile, as well as guidance and support to the identified patient representative. Moreover, preparing well-informed comments to stakeholder consultations requires building the needed expertise. These efforts require a significant investment of human resources and time capacity that can be covered either by dedicated funding or by the organisation's own funding. In the latter case, there are two options: public funding provided by public Institutions at European or national level (such as Operating Grants); or private funding provided by technologies developers. In the latter case there is a high risk of generating a conflict of interest, which undermines the possibility for the patient organisation to be involved. Suggested rewording: ~~Furthermore,~~ Financial support for ~~their participation is not expected, as the incentive to get involved is to promote the position of one's own organisation~~ patient organisations' participation is foreseen to cover the costs generated by the patient involvement activities, such as and not limited to subsistence costs, transfers and accommodation.	x	A recommendation for the future has been added

European Patients' Forum	7	160	Comment: For patient experts to understand the context of their involvement, it is important to make their contribution as systematic as possible. We understand ad hoc involvement to mean participation in a specific process. There is a risk that such involvement will not provide patients who act as external experts with the needed framework and background information that will contribute to meaningful involvement. We suggest that a patient involvement team will be needed to provide guidance and support to patients. The EMA's stakeholder involvement team includes a specific team that supports patient involvement and we recommend this to be implemented also for HTA.		Patient and clinical expert are systematically included. The term "ad hoc" is deleted as it could be misleading. It merely implies that relevant questions that arise during the procedure can and should also be asked.
European Patients' Forum	7	162-163	Comment: based on their own knowledge and expertise, patient experts should be given the opportunity to give unsolicited or additional input that may be missing from the set of questions provided by the assessor. Suggested wording to add: Based on their own knowledge and expertise, patient experts should also be given the opportunity to provide unsolicited or additional relevant input that may be missing from the set of questions provided by the assessor.	x	The questions are open ended and the patient input templates also include a question on additional information ("please include and additional information you believe would be helpful to the EUnetHTA JCA Team (e.g. ethical of social issues).
European Patients' Forum	7	170-171	Comment: patients' ability to contribute may depend on compensation of costs and time invested. Suggested wording to add: Costs generated by patient involvement activities (such as subsistence costs, transfers and accommodation) are covered by the assessor. Moreover patient experts receive financial compensation for the time invested in their contribution.	x	Thank you. This has been noted in a recommendation for the future in that section of the text.
European Patients' Forum	7	177-178	Comment: Including all patient-related terms (i.e., patient advocate, patient organisation, patient representative, patient) under the umbrella term "patient community" risks that the voice of individual patients (although very knowledgeable on the matter) could "weigh" the same as that of a patient organisation that has formed its opinion in cooperation and consultation with a		Thank you. We believe it is clearly highlighted in the guidance that patients with collective knowledge should be

			wide group of patients. Moreover, using the generic term "patient community" may create more confusion for the assessor on which specific profile should be engaged at which stage of HTA.		involved where possible. We removed the sentence regarding the patient community, which was actually not necessary for the good understanding of the guidance.
European Patients' Forum	7	179-181	Although the terms are very clearly defined and categorised in the annex, the draft text would benefit here from a clarification on how the input provided by any of these would be weighed against others. We recommend including some criteria regarding legitimacy and representativeness of the opinion.		Thank you for your comment however we don't agree that we should introduce a hierarchy of experts. We consider the input of the all experts selected to be important. In addition we consider the criteria to be put in place with regard to conflict of interest and representativeness to adequately address this issue.
European Patients' Forum	7	182	Comment: Individual patients with "collective experiential experience" are often members and representatives of patient organisations.. Patient organisations are made of patients; therefore the distinction is blurry and there are overlaps between the categories. We would like clarity on who would assess which category should be assigned to a patient. Suggested rewording: Where possible, individual patients with collective experiential knowledge, **for example from participation in a patient organisation**, should be targeted…	x	Thank you, the document has been modified.
European Patients' Forum	8	188-190	While proxy representation is acceptable when patients are truly unable to give their views, their perspective is not necessarily identical to that of the patient. We feel it is important to enable participation of patients whenever possible, and		Thank you for your suggestion, we have clarified the text and

			in addition to include the voices of informal carers. Persons with cognitive impairment, for example, can give input when the process is appropriately facilitated and adjusted for them. We recommend seeking the advice of patient organisation representing such conditions (e.g. dementia) on this aspect.		added a recommendation for the future.
European Patients' Forum	8	213-215	Comment: When patient experts have access to the JSC or JCA documents, they may realise that they need to bring on board specific expertise or may have to consult with other patients in order to submit informed feedback. A clause foreseeing this specific case must be included, implying that assessors may have to enrol the additional expert. Patient experts should also be enabled to discuss and consult with other patients in case they feel it necessary to do so on specific questions.		Disclosing the documents to an expert and allowing the expert to share the documents as he or she sees fit would not be acceptable in terms of confidentiality standards.
European Patients' Forum	8	220-239	Comment: the draft deliverable refers to D7.5 for handling COI and DOI. Following careful review of D7.5, it is still unclear what methodology is going to be applied to assess whether and how a conflict of interest is generated. Patient organisations, including EPF and EURORDIS, had suggested a clear framework to EUnetHTA JA3, that would clarify under which circumstances a patient organisation would have a conflict of interest. We propose applying the framework mentioned above, as lack of clarity on criteria leads to misunderstanding and lack of predictability on engagement.		Thank you for your suggestion, but this is out of scope for the current document.
European Patients' Forum	9	243	Suggested to add under this heading: • Umbrella patient organisations, that can in turn share the call for interest among their networks and recruit national patient organisations or disease-specific patient organisations with knowledge on HTA.	x	Text has been clarified that patient organisations and medical societies can help identify relevant external experts
European Patients' Forum	9	243-246	Suggested to add under this heading: "An accreditation process should be introduced to onboard stakeholders and experts, based on the principles of legitimacy, representativeness, expertise or experiential knowledge."	x	This is related to the general Stakeholder network under the HTAR, and does not seem appropriate for the stakeholder and expert database/selection for

					involvement in specific JSC and JCA. The database described in this guidance (section 4.1.2) is open to any external expert willing to participate in a JSC/JCA. External experts can then be selected from the database, based on the needs for the specific JSC/JCA and e.g. based on the external experts expertise - please see section 4.2.1 where this is detailed
European Patients' Forum	10	267	Comment: EPF considers there is a lot of work to be done in terms of creating the necessary conditions for meaningful patient involvement, with particular regard to information and training. Suggested rewording: "Training opportunities for patients, **patient organisations,** and healthcare professionals"	x	Thank you for highlighting this. We have added recommendations about the training purpose, however, we feel it is out of our mandate to give recommendations about the role of patient organisations in this
European Patients' Forum	10	263-269	Comment: EUnetHTA21 should consider also the role of patient organisations in providing training to patient communities and raising awareness about HTA.		Thank you for highlighting this. We have added recommendations about the training purpose, however, we feel it is out of our mandate to give

					recommendations about the role of patient organisations in this
European Patients' Forum	10	271-281	Comment: the registration form should include space for DOI connection with patient communities to assess legitimacy and "collective experiential knowledge", as well as conflict of interest and level of expertise.		This is related to the general Stakeholder network under the HTAR, and does not seem appropriate for the stakeholder and expert database/selection for involvement in specific JSC and JCA. The database described in this guidance (section 4.1.2) is open to any external expert willing to participate in a JSC/JCA. External experts can then be selected from the database, based on the needs for the specific JSC/JCA and e.g. based on the external experts expertise - please see section 4.2.1 where this is detailed. A section will be added detailing suggested fields for the registration form, in which some of the mentioned accreditation steps are included

European Patients' Forum	11	313-314	Comment: Such open call should be notified to all current collaborators of EUnetHTA 21 such as EPF, to amplify outreach to patient communities.		Thank you, this is noted.
European Patients' Forum	11	341	Proposed rewording: substitute "the patient community" for "patients", thus explicitly including patient organisations, patient advocates, etc.	x	We use patient as an umbrella term in the whole document.
European Patients' Forum	11	353	Comment: a notice of at least two weeks should be mentioned, to allow experts to review the relevant documents ahead of the JSC and JCA.		The time frame of JCA and JSC does not necessarily allow for that much time. However, the experts will be given as much time as available to review the relevant documents.
European Patients' Forum	11	360	Comment: information about medicinal products and their indications are usually publicly shared by EMA. Substantially, there would be no breach of confidentiality if this information and comparators were shared also for JCA. Suggested rewording: Stakeholders are informed of the claimed indication **and the tested medicinal product and the comparator(s).**	x	While the information might be publically available, we decide not to share this information as we do not want to ask the stakeholders about their opinions or experience with the treatment or comparators under assessment.
European Patients' Forum	13	384	Comment: the framework should establish a mechanism that allows collection of input from the national to the European level for the consolidation of PICO (Population-Intervention-Comparator- Outcomes).		Thank you for your comment, however this is out of scope as input from national experts and stakeholders is not in the remit of the HTAR and therefore it is not part of this guidance

European Patients' Forum	14	384	Comment: patient experts should be able to provide also unsolicited input when relevant, their role should not be limited to responding to specific questions.		The questionnaire includes open ended questions, as well as a question on if there is any other information experts want to provide. In an oral interview, this questionnaire will be used as a guide.
European Patients' Forum	16	393	Comment: the timeline should include an alignment phase ahead of the involvement of EU-level stakeholders, as part of the scoping process and EU assessment phase.		Thank you for your comment. We made sure the guideline is in alignment with the guideline on the scoping process
European Patients' Forum	21	503	Comment: to ensure a wide range of perspectives, not only the geographical spread should be considered but also age, gender, living conditions, etc. for as much diversity as possible.		Since we are aiming to involve experts with collective knowledge, that can represent a community broader then their member state, we have taken out the selection criteria on geographical spread.
European Patients' Forum	26	535	Comment: the definition of patient associations should indicate them as patient-driven, not patient-focused. Suggested rewording: which are ~~patient-focused~~ **patient driven**, and…	x	The definition included in the glossary is that of the EMA. We prefer not to make changes to another organisation's definition.

European Patients' Forum	5	N/A	The document explains that during EUnetHTA JA3, significant work was carried out to create a framework for the involvement of patients, patient representatives and patient organisations in the conduct of JCA/CAs and JSCs. Such framework should be summarised/explain here or, at least, include a link to a website with more information on this process.		Thank you for your comment. Our guidance is informed by work done previously in JA3, but we decided to not summarize previous work.
European Patients' Forum	5	N/A	"For JSC, the EUnetHTA Early Dialogue Secretariat contacted European and national associations as well as EURORDIS" – however, EURORDIS is an European patient association and should be represented as such, and not as a separate type of entity.		We will consider this when finalizing the deliverable, however, we will not be able to amend the published project plan
Dr Rosa Giuliani, European Society for Medical Oncology (ESMO)	General	n/a	ESMO is the leading professional organisation for medical oncology. With more than 25,000 members representing oncology professionals from over 160 countries worldwide, ESMO is the society of reference for oncology education and information. With the aim to ensure equitable access to cancer medicines, ESMO has developed several resources and tools, among them the ESMO-Magnitude of Clinical Benefit Scale (ESMO-MCBS). The scale uses a rational and structured approach to score the clinically meaningful benefit of medicines approved by the European Medicines Agency (EMA). The scale is used by various countries to prioritise cancer medicines and help frame the use of public and personal resources. ESMO considers that, for cancer medicines, the ESMO-Magnitude of Clinical Benefit Scale (ESMO-MCBS) may be instrumental in this process and help avoid possible duplication of efforts when used from the beginning when conducting JCAs. For further information the contact details for the ESMO-MCBS Working Group are mcbs@esmo.org. Additional details on the ESMO-MCBS can be found here: https://www.esmo.org/guidelines/esmo-mcbs		Thank you for your comment

			Furthermore, ESMO believes that it is critical that healthcare professionals are involved from the beginning of the discussion in JCAs and JSCs, and that tools that are already being used by healthcare professionals are integrated in the process.		
Dr Rosa Giuliani, European Society for Medical Oncology (ESMO)	6	119-122	"Patient and healthcare professionals can provide important knowledge about the disease and insights into treatment processes", when they are involved from the first stage of the evaluation process.		Thank you for your comment. We will consider this feedback when finalising the guidance
Dr Rosa Giuliani, European Society for Medical Oncology (ESMO)	9	247-257	"Approach relevant organizations directly via e-mail, either at EU or national level. To identify relevant organisations, the following could be consulted:" ○ … ○ For cancer treatment and care, the European Society for Medical Oncology has a large pool of experts that can be identified to provide expertise for solid tumours, rare cancers, and supportive and palliative care.		Thank you for this offer. We have, however, not addressed it in the document, as we do not want to exclude other organisations.
Dr Rosa Giuliani, European Society for Medical Oncology (ESMO)	12	369-370	"For each JSC, the input of external experts and for each JCA, the input of external experts as well as stakeholders should be sought" during the very first stage of the process.		Participation is sought from the beginning of the process, but can be sought throughout the process if needed.
Piotr Szymanski, ESC	7-8		It is crucial that learned societies like the ESC are involved in consultations/assessments, to provide inputs based on an academic perspective, especially considering clinical practice guidelines. For this reason, the process of involving stakeholders in JSC/JCA productions shall be better described. A general remark is that academia plays a key role as provider of high-quality evidence and evidence-based clinical practice guidelines, that set up a management standard for practicing physicians, and should be a separate stakeholder group, distinguished from the healthcare professionals' one.		Thank you for your comment. Involvement in a JSC or JCA is based on requirements from the HTAR.

Piotr Szymanski, ESC	8	2.3	Clinical experts' rules of collaboration should be transparent and clear. Healthcare professional organizations should be able to give input also on JSC, provided that confidentiality is ensured. Selection and notification processes should be clearly described.		Thank you for your comment, but we will not open the JSC process for stakeholders due to confidentiality.
Piotr Szymanski, ESC	8	3.1	Confidentiality rules should be described not only for external experts, but also for professional organizations and their representatives, who should be able to access JCA/JSC documents under appropriate confidentiality agreement.		It is not envisioned that stakeholders get access to confidential information, therefore we see no need to set up such process.
Piotr Szymanski, ESC	9		The following expressions should be rephrased, to ensure clarity and transparency: - "to identify relevant organizations, the following *could* be consulted" - "for JCA, external experts and stakeholders *can also* be recruited through a public call. - "identified organizations/stakeholders *may be able to* assist in identifying external experts for a JSC or JCA". The recruitment process should be well described, transparent, and enable all relevant organizations to respond to the call. It is especially important for all relevant stakeholders to be able to propose external experts for a JSC or JCA and the selection process should be explicit.		A section has been added to clarify the selection process of external experts
Ruben Casado ESC	9		Associations with a specific knowledge should be invited to propose clinical experts; eg. European Society of Cardiology, as the biggest association of cardiologists in the world. This approach will make the process simple and transparent and will promote the most experienced clinical experts in the field of interest.		When we start the search for external experts, we of course will target specific organisations that have a connection to the disease area.
Piotr Szymanski, ESC	11		The process of involving stakeholders and external experts should be clarified, especially with respect to external experts identified by professional organizations. The latter should be involved in both JCA and JSC, provided that confidentiality is assured.		Thank you. The definition of both stakeholders and experts has been

					clarified. We have also clarified the recruitment and selection of both. Nevertheless, stakeholders will not be involved in JSC due to the confidentiality of the JSC procedure.
Piotr Szymanski, ESC	16		JCA time points of involvement includes "*Ad-hoc* involvement of 'European' expert" in the assessment phase. Systematic expert involvement rather than "ad hoc" approach should be considered.		Thank you, this will be rephrased.
Piotr Szymanski, ESC	21		Professional organizations should be consulted during the development of implementing acts. Umbrella organizations such as ESC, gathering all EU National Cardiac Societies, may ensure geographical spread of experts. Nevertheless, expertise should be given clear preference over any other criteria.		This comment is out of scope of the current document, and will need to be considered by the HTAR Secretariat when setting up the Stakeholder Network
François Houÿez, EURORDIS			Eurordis will not comment on the templates at this stage as our experience is that the best way to assess their relevance and completeness is when there is a procedure and stakeholders start using them. Templates are or should be permanently evolving. Otherwise commenting on them outside of a procedure can become a totally abstract and irrelevant exercise.		Thank you.
François Houÿez, EURORDIS	6	114-124	Maybe some general principles could be added (below is adapted from the Guidelines for Stakeholder Engagement in Health Technology Assessment in Ireland, Health Information and Quality Authority): **Inclusiveness and diversity** Ideally all stakeholders who have an interest in specific HTA activity (JSC or JCA) should be involved, taking into consideration the EU diversity in citizenships, gender… **Transparency** Information should be shared equally with all stakeholders; no stakeholder should be given preferential treatment. The exception is commercially sensitive or confidential information, or where the General Data protection Regulation precludes sharing of the data. It should also be clear to stakeholders what they		Thank you and we agree with many of the points made. Work is ongoing in relation to the documentation of the contribution of experts as this will impact across a number of deliverables and not just D7.2/7.3.

			can and cannot influence through their involvement. **Commitment and responsibility** Respect should be shown for all stakeholders by giving the appropriate priority and resources to the engagement process and demonstrating that it is a genuine attempt to understand and incorporate other opinions even when they conflict with pre-conceived ideas. It should be established from the outset of the HTA and communicated to the stakeholders how the HTA procedure will benefit from stakeholder engagement. Stakeholders should agree with the procedures and scientific rules and be given adequate opportunities to contribute. **Accountability and visibility** As soon as possible after the end of the engagement process, participants should be provided with an unambiguous account of when their contributions have – or have not – influenced the HTA activity. This can be achieved by suitably recordings of interactions between assessors and stakeholders where relevant actions are highlighted and the outcomes of those actions are reported to the stakeholders. **Responsiveness** The assessors should be open to the idea that their pre-existing ideas can be improved, and that they will, if necessary, amend them. Stakeholders should perceive that their voice will be taken seriously, and that changes can be made. **Willingness to learn** Assessors and the stakeholders should be encouraged to learn from each other; this means giving sufficient time for face-to-face meetings where mutual understanding can be reached on complex topics.		
François Houÿez, EURORDIS	6	119-124	One first important objective of involving civil society, patients in particular, in HTA activities is to increase the transparency and public trust for the assessments of health technologies. Patients and representatives should have an opportunity to understand how technologies are assessed, and how decisions are prepared, as direct witnesses of the procedures, even if they do not directly contribute to the HTA. In addition, when they can contribute to the activity, and as patients (and other stakeholders) have self-interest in a given HTA topic, their involvement is seen as both rational and likely to contribute to the quality and legitimacy of the process and outcomes.		Thank you for your comment. We will consider this feedback when finalising the guidance

			Patients can also comment on the selection of the relevant population and comparators, as healthcare professionals do (but based on different experience). Suggestion for rewording When taking part in HTA, patient and healthcare professionals can better understand how technologies are assessed, to the benefit of transparency. In addition, they can provide important knowledge about the disease and insights into treatment processes. Their input can help the assessment team select relevant outcomes or characterise the appropriate patient population and improve the relevance and legitimacy of assessments and recommendations. Their input can additionally support the assessment team's selection of relevant population and comparators based on their expertise from clinical practice and help interpret clinical trials results. This is critical to the JSC and JCA process.		
François Houÿez, EURORDIS	7	154	"Inherent conflict": this is not immediately clear. If the idea is to say that patients can be influenced as they have an immediate interest to use the authorised technology (their health or their life is at stake), then the term "inherent interest" would be more appropriate.		Thank you. This has been modified in the document
François Houÿez, EURORDIS	7	154-157	Article 5.2 of HTAR states *"the representatives appointed to the Coordination Group and its subgroups, and patients, clinical experts and other relevant experts participating in any joint work, shall not have any financial or other interests in the health technology developers' industrial sector which could affect their independence or impartiality"* Providing information on the funding of their organisation will only address the interests of financial nature, but not the other ones (participatory, intellectual, career-oriented…).		For any individual expert involved, we indeed will ask for a completed DOI form and the other potential interests beyond financial ones are addressed
François Houÿez, EURORDIS	7	156-157	Even if the possibility to provide the opinion of the organisation is an incentive in itself, resources are needed to gather the views of the members, to explain them the HTA procedures and why their views are sought, to identify potential experts and to mentor them, to express the different views different members of the organisation can have etc. This has a cost for the organisations, part of which can be supported by the Operating Grants provided by the European Commission, but sometimes these costs are bear by industry, a situation which should be avoided. Therefore, EUnetHTA21 and/or the secretariat of the European Cooperation		It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting compensation

			on HTA should envisage the possibility to provide financial support to stakeholder organisations that are involved.		procedure and rules for experts participating in a JSC and/or JCA
François Houÿez, EURORDIS	7	162-163	Not only external experts can respond to questions, but they can also raise issues, concerns or share facts and data, or discuss/interpret data that are not in direct response to questions from HTA. The involvement of external experts should be a two-way communication, not restricted to external experts just replying to questions.		Thank you for your comment. We will consider this feedback when finalising the guidance
François Houÿez, EURORDIS	7	170	Remark on EUnetHTA21 policy on managing conflicts of interest: one situation that is a conflict is when the HTA assessor (or external expert) status is "Employment at a company producing the technology under assessment, a comparator, or a relevant technology under development within the last 3 years; employment at a consultancy or contract research organisation providing services related to the technology under assessment, a comparator, or a relevant technology under development; or employment by relevant lobby group within the last 3 years". One question is about HTA assessors or external experts who are employed by a governmental organisation / authority that decides on the reimbursement of the technology (appraisal) or pays for the provision of the technology. This includes public and private health insurance services. Any employee of such services/organisations could be influenced, as these decisions have huge financial interests. HTA assessors should be independent and not exposed to this influence.		Thank you for your comment, however, this is outside scope of our D7.2 document, as we follow the finalized COI guidance. In D5.3.2 (selection criteria for assessor and co-assessor), this independence is considered as per HTAR as JSC assessor or co-assessor cannot be JCA assessor or co-assessor.
François Houÿez, EURORDIS	8	205-239	Confidentiality is one thing; prevention of insider trading is another one. There is no paragraph on how EunetHTA21 plans to prevent insider trading.		Thank you for your suggestion, but this is out of scope for the current document. The comment will be passed on to the Conflict of Interest Committee
François Houÿez, EURORDIS	8	207-209	On the contrary, all external experts should be given the exact same information. No difference should be made among external expert, it is for each one of them to decide where he/she can contribute; but no one should pre-decide on their behalf. With appropriate mentoring and guidance, each external expert can		Thank you, the document has been modified

			understand the different parts of the documents and where he/she prefers to focus on. Pre-defining who can have access to chich part of the documents is patronising and it implies the existence of a hierarchy among external experts.		
François Houÿez, EURORDIS	8	214-218	For JCA, the date when confidentiality ceases is clear (publication of the final report) but for JSC, it is not. It should be specified.		JSC are confidential forever. This has been made more explicit in the guidance document.
François Houÿez, EURORDIS	9	253	European Reference Networks and their respective EPAGs (European Patient Advocacy Groups)		Thank you this has been modified in the text.
François Houÿez, EURORDIS	9	260-262	Stakeholders and/or external experts recruited via Social Media Channels (and social networks as well?): these channels are not registered organisations in EU Member States. There are no legal entities, there is no legal responsible person (sometimes the founder of the social media is held legally responsible, but the responsibilities are not the same as for an elected representative (i.e president) of a registered patient or healthcare professional organisation. It is important and useful to explore the involvement of stakeholders and external experts recruited via websites and/or social media channels, but the nature of these channels require further reflection.		We agree with your comment. We wish to clarify that we specifically refer to the EUnetHTA social media channels, as a platform to disseminate the open call. We indeed do not intent to use external social media channels/social networks
François Houÿez, EURORDIS	10	292	The server in which data will be stored should be located in one of the EU MS. Servers located in the US are not compatible with data protection (no safe harbour).		Section 4.1.2 addresses the database solution should be GDPR compliant
François Houÿez, EURORDIS	11	313-316	This process will take time and will require resources (communication) to reach out a large number of experts. National HTA bodies that have not started to work with some stakeholders, eg patient organisations, have no or little ability to contact them. To collect large numbers of data, the collection should continue beyond the duration of EUnetHTA21.		The current EUnetHTA 21 stakeholder repository is not set up in a way to suit the needs of an expert database for a JSC and

			For patient experts, the maintenance costs will be substantial, as people can stop being active due to health status, or changes in the governance of the organisation when new representatives are elected (annually).		JCA. Additionally, EUnetHTA 21 will not have resources to set up a dedicated external database for this purpose
François Houÿez, EURORDIS	11	353-355	This is very wrong. Involving does not just mean asking questions and restricting the exchange to the provision of responses. Involving means two-way communication, each party should be ready to listen to the other and open mutual questioning. All external experts should be given access to the information from the files submitted by the HTD on the same basis than all other experts. Otherwise, the procedure can be biased, with some experts being denied access to information, creating two levels with a category of higher-level experts and sub-experts.		Thank you for your comment. We deleted the sentence
François Houÿez, EURORDIS	15	386-390	During the JSC procedure, the indication can change, for example a different stage of the disease might be chosen for the development. From the experience in the SEED project, when it happened that the call for patients had to be revised during the procedure, it proved to be difficult to start the identification of suitable patients again. How will this be solved with the timelines indicated in 5.1.1?		Joint scientific consultations are conducted based on the information submitted with the application form and later with the final Briefing Book. If an indication changes significantly, the company is advised to request another JSC. Changes during a JSC can only be considered to a limited extent.
François Houÿez, EURORDIS	19	430-432	It is essential to evaluate the experience of stakeholders and of external experts, and to make sure expectations were met, it is also essential to collect the views of HTA experts vis-à-vis the contribution of stakeholders and/or external experts. If overall HTA experts report that in only 20% of the procedures the contribution of stakeholders and/or experts was valuable, then an analysis of the reasons why and a reflection on how to improve this needs to be triggered.		Thank you for this helpful suggestion. We agree that such a suggestion could be helpful within the future process under the HTAR CG. this will be

			If they report stakeholders and/or external experts' contributions are valuable in 80% of procedures, then the picture is different. Stakeholders and external experts might report being satisfied (simply because they were involved) even if overall their contribution was poor. The opposite is also true, they might be dissatisfied even when HTA experts on the contrary are extremely positive about their contribution. Hence the importance of evaluating the involvement both from the stakeholders/external experts and from the HTA experts' perspectives.		reflected in the guidance.
François Houÿez, EURORDIS	20	447-449	It will be important to involve all HTA bodies are assessors or co-assessors. If always the same limited number of HTA bodies serve as assessors or co-assessors, then large parts of EU stakeholders / external experts will not be given a chance to contribute, and this would limit the contribution of the EU civil society as a whole.		This comment is out of scope of the current document
François Houÿez, EURORDIS	20	458-459	EURORDIS fully supports this recommendation		Thank you.
François Houÿez, EURORDIS	20	462-463	Even with a dedicated unit for the engagement of stakeholders, and with a register of external experts, the EMA relies largely on eligible patients', consumers' and healthcare professionals' organisations to identify experts. For example, since 2000, the EMA systematically shares letters received from developers when seeking protocol assistance (applicable to orphan medicinal products only) with EURORDIS, so that EURORDIS can help flagging meetings where patient experts are most needed and identify patients for the procedure. Each year EURORDIS identifies and mentors tenths and tenths of patient experts.		Thank you for highlighting. We understand the importance. We believe our procedure describes the role patient organisations can have in identifying individual patients
François Houÿez, EURORDIS	22	510-511	External experts should always review draft JSC of JCA reports, in order to comment on whether the report faithfully express the views they shared, on the understandability and clarity of the report, even if this is complex to implement.		For JSC, this is foreseen and it is reflected in the JSC procedural guidance. For JCA, this will not be possible, but the full response to the questionnaires will be published In case of an interview, a summary will be shared for

					verification with the expert.
PCIG			**General comment:** As with HTA consultations, PCIG recommends that all consultations are established with advance notice of deadlines to ensure that appropriate input from a wide range of patients can be obtained. We would expect the short consultation period and its timing, August, will limit the ability of these documents to benefit from the expertise of patients and their associations. An extension to the deadline is one possible remedy.		We note this comment for the evaluation of the general public consultation process
PCIG	p.6 p.7	1.1 2.1, Ln	The literature (eg) suggests that it is essential to state a clear goal for patient involvement. Additionally, *HTAi's Values and Standards for Patient Involvement in HTA* (2014)https://htai.org/patient-and-citizen-involvement/ state that 'patients have knowledge, perspectives and experiences that are unique and contribute to essential evidence for HTA'. For this reason, the document should contain: • A clear and distinct statement **of goal(s) or aim(s)** for involving patients in JSC and JCA which articulates the value of lived experience as a source expertise and a unique contribution that can be made by patients and their representatives such as carers and staff/volunteers from patient associations (it should not be blended with the aims for involving health professionals who bring different expertise). • A clear **framework** setting out the who, when, where and how (methods and approaches) which is guided by the goals to increase its likelihood of being meaningful. We recommend INAHTA's position statement on patient involvement (2021) as a useful guide. Note also HTAi's quality standards for general HTA processes, especially the need for reflection and review to allow continuous improvement. **Financial compensation**: The statement: "financial support for their participation is not expected, as the incentive to get involved is to promote the position of one's own organisation" confuses an interest in the outcomes of HTA, with a remit to take part in it. Patient associations are set up to support patients and not HTA. Patient associations spend considerable time and resources on preparing responses in the template formats. By not make any funding available, it demands associations choose between other work to support patients and contributing to HTA. It does not appear consistent to		Additional clarity has been given on the value of patient input and a recommendation for the future has been made regarding investigating a remuneration process

		2.2	require information regarding their sources of funding, but not demonstrate a recognition of the limits of funding sources and patient association budgets. It is likely to reduce the number and types of groups who can take part (limiting the diversity of patient involvement). Additionally, a failure to financially compensate patient experts is likely to limit those experts able to take part. This should not be an area postponed for future. It is clearly stated in the PARADIGM (2021) guiding principle #8 Financial Compensation and Reimbursement of Expenses: “Patient advocates deserve a reasonable financial compensation for their time and contribution when acting in advisory roles, consultancy, speaking roles or other collaborative work with third-party organisations or institutions.” Further guidance is provided here. The **rationale for seeking individual patients in preference to representatives of patient associations** is not clear, especially in JCA. A framework with clearly defined roles and criteria may aid in clarifying this. At present, it is unclear why the ability of patient associations to bring a broad range of knowledge and experiences to the JCA would be limited to written submissions which do not allow for the dynamism and sense making of committee dialogue. We note the **definitions** and suggest also considering Street J, Stafinski T, Lopes E, Menon D (2020). Defining the role of the public in Health Technology Assessment (HTA) and HTA-informed decision-making processes. International Journal of Technology Assessment in Health Care 1–9. https://doi.org/10.1017/S0266462320000094. This work was undertaken by one of us PCIG’s working groups to aid understanding of the rationale for different terms and their involvement All groups of people included in the glossary are part … □ All groups of people included in the Glossary on Patients – except for citizens - are part … : the ‘0’ should be replaced by ‘Appendix 2’ This sentence puts the pressure on patients to acquire scientific knowledge to participate. This expectation from HTA bodies may be a barrier to participation		

		Line 176: Line 181 Line 184-187 3.1, ln 207 4.1.2	and will not help HTA researchers to incorporate experiential knowledge by making non-scientific voices less legitimate and therefore, less heard. HTA researchers could profit more from another approach. Our suggestion: "Facilitations skills and training in participatory methods can help those who conduct EUnetHTA 21 JSC and JCA to make the process more fruitful and efficient" It is essential that patient experts and their associations taking part in JSC and JCA receiving appropriate information to support their effective contribution. Developers should submit a Plain Language Summary or Summary of Information for Patients which can be checked to ensure content is accurate and non-promotional, then handed to the external patients and experts as a base information in addition to the specific information from the package, that will be required to give a qualified input. This document can be developed locally post JCA and provides a tool for mutual understanding. See our Summary of Information for Patients international template which can be adapted as needed. What measures will be taken to ensure this registration is accessible for all? Promotion of registrations appears to be limited to those already connected to EUnetHTA? How will you build beyond this to ensure inclusivity and avoid capture? Will non approved be given clear feedback as to why not include in register? HTAi's Values and Quality Standards state that 'patient involvement processes <should> **address barriers** to involving patients in HTA and build capacity for patients and HTA organizations to work together. In the stage of transition, it should be possible to contact the people in the **EUnetHTA21 database** and motivate them to register in the future database / registry. Replace '0' with 'Appendix 1' (1) Before being involved, patients and patient experts need to be informed on the aims of the patient involvement for their specific involvement and this information should be aligned and clear for all stakeholders.		

	p.10 p.11 p.13 p.16 p.29 5.1.2	 Line 288 Line 344 Table 4-1:	(2) They should also know what type of patient / clinical stakeholders are involved for what purpose; potentially, how the input is intended to be used / implemented. (3) They should get an overview (simple) on the respective HTA process and where in the process their contribution will play a role Joint Clinical Assessment (JCA): What kind of information will be taken into account and how? Will there be a consultation of the report, where patient experts / stakeholders can react? Page 16; 5.1.2 JCA / EU Assessment phase: Patient experts should be standard not ad hoc. Consultation on draft report needed. On the first page of the **questionnaire**, asking experts if they understood the objectives and their role confuses EUnetHTA 21's responsibility to clearly articulate these. When HTA bodies imply a deficit in the experts when they do not understand, it may be interpreted as patronising and demonstrate a lack of commitment to transparency and accountability. For example, we suggest: 'Did we explain the general principle of the EUnetHTA 21 procedure in a way that was clear and meaningful to you?" 'Did we explain your role in the EUnetHTA 21 procedure in a way that was clear and meaningful to you?" Additionally, the quantity of opportunities (Q.5) may be less important than the quality of opportunities, eg an ability to result in shared learning. We are pleased to note the adaption of our template and believe its content areas continue to be useful. Based on experiences adapting it around the world we suggest: • Some information captured by patient associations may be common to many submissions. Out of respect for patient associations' time, some HTA bodies, collect the common information, and keep it on file so that patient associations only add new information any provide updates as needed. • Our template was created with patient associations in mind, however, it has been adapted for use in several countries for individual input. When		

	Templates		this happens, we recommend the template is prefaced with a warning to acknowledge that time spent reflecting on personal experiences (potentially the worst experiences of their lives) and those of others in patient communities (often friends) is likely to cause distress. Support options should be suggested. ☐ The process should include a clear statement to help set expectations of contributing, information about how inputs are going to be used or incorporated, how feedback will be given and a thank you.		
Norbert Gerbsch for IGES Institut GmbH and HealthEcon AG	6/7	130-134	**Comment:** DRAFT GUIDANCE: "This guidance document explains (1) the role of stakeholders on the one hand and of patient and clinical experts on the other hand during the production of JSC and JCA, (2) the recruitment of stakeholders and experts (patient and clinical), (3) the process for collecting stakeholder and expert input, (4) the documentation of input in the JSC or JCA reports and (5) the evaluation process of their involvement." A general definition of the term "expert" is not operational. This has to be accepted due to the variability of diseases, healthcare systems and research questions. Though it is of utmost importance to justify the selection of participating experts. **Suggestion:** The selection of external and clinical experts should justify why a specific person is considered to be an expert (e.g. years of experience, role and job, numbers of patientes treated etc.). The same applies to the selection of patient representatives and patient organisations, as there may be different organizations on national as well as on european level.		This comment is out of scope, as we follow the DOI guidance which is publically available
Norbert Gerbsch for IGES Institut GmbH and HealthEcon AG	9	247/248	**Comment:** DRAFT GUIDANCE: „Approach relevant organizations directly via e-mail, either at EU or national level. To identify relevant organisations, the following could be consulted:..." Expert status must be confirmed regularly. Also new experts must be considered for the databases and experts must be considered, who are not		Thank you, text has been clarified

			listed in respective networks and databases. Otherwise this would risk to create a "closed shop" without pressure to regularly legitimate expert status. Networks and databases must not be defined as exclusive sources to identify external and clinical experts **Suggestion:** „*One possible option to identify external and clinical experts is to approach relevant organizations directly via e-mail, either at EU or national level. To identify relevant organisations, the following could be consulted (list is non-conclusive). In any case, the selection of specific experts will be justified*....."		
Norbert Gerbsch for IGES Institut GmbH and HealthEcon AG	16	Figure 5-2 – time points of involvement in JCA process – "EU Assessment phase"	**Comment:** DRAFT GUIDANCE: „Ad-hoc involvement of 'European' expert (…)" Why is „European" set in quotation marks? **Suggestion:** Please provide a definition of european expert. What is alluded to: The place of professional residence, the fact that an expert has collected his or her expertise in Europe, a combination of both or other affiliations to Europe? Is Europe meant in the sense of the area were HTAR applies?		Thank you, this has been clarified in the text.
Norbert Gerbsch for IGES Institut GmbH and HealthEcon AG	21	501-505/	**Comment:** DRAFT GUIDANCE: „(…) as a minimum geographical spread should be targeted, e.g. trying to identify patient and clinical experts from southern, western, northern and eastern Europe. (...) However, recruiting experts, assessing their COI and consolidating input in a JSC or JCA takes significant resources and it may not always be possible to identify experts from each region." The argument of required resources must not prevent the inclusion of input from different regions and healthcare systems. There are different PICOs, representing the needs of European MS. It is contradictory to this approach to potentially reduce the regional spread because of the necessary resources. HTDs have to consider all different PICOs too, irrespective of required resources. It is therefore suggested to couple the regional spread to the regional spread of the PICOS submitted by member states which might be a		Since we are aiming to involve experts with collective knowledge, that can represent a community broader then their member state, we have taken out the selection criteria on geographical spread.

			way to reduce the necessary resources. **Suggestion:** "*The selection of patient and clinical experts must represent the geographical spread represented by the different PICOs*."		
ISPOR – The Professional Society for Health Economics and Outcomes Research	6	119	We suggest amending this wording to "Patient and healthcare professionals provide important knowledge about the disease, treatment processes, treatment outcomes, adherence issues and unmet medical need." - this wording indicates the additional areas they contribute to, and emphasizes that not only they "can", but that they "should" provide such knowledge. There are several other places in this section where "can" is used, which could suggest something is optional. The necessity of patient involvement should come through in all the language used. The 2021 EU Regulation on HTA (Point 1 and Articles 11, 4, and 18.6), recommends using the phrases "shall/should". L_2021458EN.01000101.xml (europa.eu)		Thank you for your comment. We will consider this feedback when finalising the guidance
ISPOR – The Professional Society for Health Economics and Outcomes Research	8	206-218	We agree that confidentiality is critical in the process. The Confidentiality section makes it very clear that documentations and communications are well kept and the JCA report remains confidential until published.		Thank you.
ISPOR – The Professional Society for Health Economics and Outcomes Research	8	206	We recommend that EUnetHTA takes the initiative to have a separate section for confidentiality for stakeholders involved (in this case, they are patients and healthcare professionals). This section will help inform that stakeholders' information will be stored safely and will not be released without further permission, which will ultimately promote involvement and engagement in HTA.		It is not envisioned that stakeholders get access to confidential information, therefore we see no need to set up such process.
ISPOR – The Professional Society for Health Economics and Outcomes	8	207	We think it helpful to address confidentiality from the perspective of patients and healthcare professionals. Emphasizing such that information provided by patients, patient advocate groups, clinicians and other healthcare professionals is well kept and remains confidential unless otherwise indicated.		Thank you, we agree with this

Research					
ISPOR – The Professional Society for Health Economics and Outcomes Research	9	243-367	We agree that the process of recruitment of stakeholders and external experts and further involvement should be clear and appropriate. We feel that the guidance makes the process very clear in this section.		Thank you.
ISPOR – The Professional Society for Health Economics and Outcomes Research	9	243	We recommend EUnetHTA considers adding a separate section at the beginning of this Section 4 Process where considerations about diversity, equity, and inclusion are emphasized. We believe that the process of stakeholder engagement should not only lay out the technical process of engagement, such as timing, documentation and dissemination, but rather advocate an open, transparent, diverse, inclusive and equitable environment throughout the engagement process.		Thank you for your comment. We agree, and we addressed this as other comments highlighted this also
ISPOR – The Professional Society for Health Economics and Outcomes Research	9	244	Emphasizing that the process is transparent will facilitate information sharing among key stakeholders. We also believe having a section to address the inclusive and friendly environment will make sure all parties in the HTA process be respectful and accountable for their activities.		Thank you for your comment. We agree that these aspects are important, but we believe these are standard practices
ISPOR – The Professional Society for Health Economics and Outcomes Research	11	313-317	You may be aware that EUPATI maintains a network of patient experts. It may be worthwhile for EUnetHTA to make reference to EUPATIConnect in this section and to liaise with EUPATI to investigate and efficient way for patient experts to be included in the database.		Thank you for this comment. Yes, we are well aware of EUPATI and have had patient experts who were graduates of their program involved in past EUnetHTA work.
ISPOR – The Professional Society for Health Economics and Outcomes	11	319	It would be useful to provide an explanation of how the data are preserved and kept. A flowchart may be useful for describing the process covered in the SOP.		There is a brief section detailing what information should be outlined in a SOP, and it covers data storage and maintenance. This

Research					will be done by the future structure
ISPOR – The Professional Society for Health Economics and Outcomes Research	13	384	It would be worthwhile to collect data on unmet medical needs when collecting stakeholder information.		Thank you, if experts or stakeholders find it relevant to comment on, this can be done as part of the stakeholder input template
ISPOR – The Professional Society for Health Economics and Outcomes Research	16	406-407	We suggest amending this sentence to "… to adequately reflect patient and healthcare professional involvement the method and timing of involvement, as well as the extent to which patient and healthcare professional influenced the JJSC or JCA overall, should be described in the JSC or JCA report." We realize the inserted phrase is mentioned in the table, but feedback on the results of patient involvement has often been neglected in the past and should be emphasized here.		Thank you for pointing this out. This section has been re-written.
ISPOR – The Professional Society for Health Economics and Outcomes Research	25	539	It would be helpful to provide a definition for patient advocate or include patient advocate in the patient representative's definition.		We added a definition of a patient advocate, based on the definition of an advocate in the HTAi Glossary. "Patient advocates speak on behalf of a patient organisation. They are closely involved with patients and are able to voice any concerns and views of a patient group."
Marjorie Morrison, Lymphoma Coalition	General		**<u>Inclusion of health equity in health technology</u>** Health technology decisions rely on evidence to demonstrate cost-effectiveness/efficiency. As a result, issues relevant to health equity - namely the negative implications of considering cost-effectiveness/efficiency in the absence of health equity – may further contribute to an increase in disparities and inequities. (2) We promote full consideration of health equity as we believe inclusion of health		Thank you. This comment is outside scope of the deliverable.

			equity in health technology and interaction is parmount to help: (a) define where health equity clearly intersects with health technology (b) identify where health technology may further address, reduce, and close health inequities, including implementation of health equity in health technology appraisals (c) determine what methods/methodology will be utilized in the quantification of health equity alongside cost-effectiveness, with equal consideration afforded to both (d) adopt best practices that embed health equity as a key consideration in health technology reports (e) build a case for support for future resource allocation.		
Marjorie Morrison, Lymphoma Coalition	General		**Cost-effectiveness** In consideration of the implementation of health equity in health technology, we also raise the importance of cost-effectiveness analysis and question how patients will be engaged in value assessment frameworks to inform and/or guide future decision-making processes related to health technology.		Thank you. This comment is outside the scope of this deliverable.
Marjorie Morrison, Lymphoma Coalition	General		**Barriers** Language barriers impede patient participation in health technology however, there are other barriers that may also impact patient participation that require consideration. For instance, we understand that when designing standards that impact accessibility in relation to digital health literacy, the Web Content Accessibility Guidelines point to recommendations that include, "ensuring a high ratio for colors; increased text size, and not using color alone to convey information." (3) We therefore anticipate that any potential barriers to patient participation will be addressed accordingly.		Thank you for your suggestion. We agree with this and we will add a recommendation for the future that all information/templates should be in accordance with good practice of digital health literacy and we will refer to the Web Content Accessibility Guidelines.
Marjorie Morrison, Lymphoma Coalition	General		**Training, tools and resources** It is our experience that patient perspectives of low-to-middle income countries are more likely to be under-represented in health technology assessment processes due to factors such as insufficient support, lack of resources, and/or insufficient training to accurately interpret data, apply key findings and/or draw		Thank you for your comment. A recommendation will be added which reflects that any training and dissemination activities

			succinctly on experiential knowledge to complete template requirements. As such, we point to the need to address the ongoing and evolving demand on patients to contribute by implementing practical and supportive solutions, such as regularly scheduled training, tools and/or resources to promote, support and sustain robust patient participatory practices.		should also focus on the patient perspectives that are likely to be under-represented in HTA.
Marjorie Morrison, Lymphoma Coalition	7	182-187	**<u>Experiential knowledge</u>** Fundamentally, the application of patient experiential knowledge is informed by the "impact and the effects of a technology on their condition and on different aspects of their life," is critical to the integration of patient values, needs and experiences. It is our understanding that priori knowledge (or "that which comes before" or from an earlier time and/or experience) may occur, for instance when patients' with refractory lymphoma or a patient with experience of second-line therapies may reflect on earlier experience and/or knowledge acquired during past treatments and/or related therapy outcomes outside of the health technology. The "EUnetHTA 21 – Individual Patient Expert Input Template for Joint Clinical Assessments (JCA) and Joint Scientific Consultations (JSC)" template introduction would benefit from further clarification of experiential knowledge in the context of an initial diagnosis of disease and/or the existing disease/condition. At present, the introduction notes the "range of views and experiences with the disease/condition for which the health technology is being assessed." This may be viewed as subjective and therefore open to interpretation. In consideration of the above, we propose the definition of experiential knowledge in the context of patient involvement be reviewed to ensure clarity and clear understanding regarding its interpretation and application.		Thank you. The definition of experiential knowledge has been modified.

Marjorie Morrison, Lymphoma Coalition	3	68	**EUnetHTA 21 – Individual Patient Expert Input Template for Joint Clinical Assessments (JCA) and Joint Scientific Consultations (JSC)** **<u>Adverse events and/or toxicities</u>** When seeking additional personal information to better interpret and/or process responses accurately, the template includes disease stage/severity but omits adverse events and/or past toxicities. As evidence-based data points to these specific issues and/or areas being of signficiant concern for patient and carer alike, we propose this be addressed with the inclusion of an area to capture adverse events and/or past toxicities from a patient perspective as (or if) they relate to the health technology.		Thank you. The reason we ask these background questions is to be able to interpret the answers given and to ensure the patient fits the population under assessment. Information about AE or toxicities is covered in the other questions.
Marjorie Morrison, Lymphoma Coalition	9	245	**<u>Recruitment of stakeholders and external experts</u>** We understand that "several recruitment strategies have been developed" with largely identical mechanisms." We note that there is no indication of developed retention strategies and suggest it would be beneficial to provide additional clarity and/or indicate the development of same.		Experts will be invited to sign up for the expert database, thereby allowing them to be contacted for different procedures. Experts will need to confirm annually their wish to remain in the database.
Marjorie Morrison, Lymphoma Coalition	10	267	**<u>Engagement of patients and healthcare professionals</u>** **Training opportunities.** With respect to the "consideration of training opportunities for patients during EUnetHTA21 to inform about HTA activities and possibilities to engage in HTA processes," we do not see this as optional or for consideration. Rather, as training opportunities serve as a catalyst to promote enhanced patient participation, we propose a firm commitment to incorporating regularly scheduled training opportunites, together with EMA, in a EUnetHTA 21 training and education calendar. **Timely exchange of information.** We note, as per the European Medicines Agency, that the multisectoral		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance, EUnetTHA 21 participates in EMA training. Additionally, the recommendation will be expanded so that in the future it can

			Patients' and Consumers' Working Party (comprised of 30 members) have a mandate to "provide recommendations to the EMA and its Human Scientific Committees on matters of direct or indirection interest to patients in relation to medicines for human use and monitor the overall interactions between EMA and patients and consumers." (1) As we are aware of the similarities between the EMA PCWG and the EUnetHTA 21 Task Group on Patients and Consumers and Healthcare Providers, and as we firmly believe the EMA PCWG model and commitment to engaging patient and consumer organisations formal structure and framework is a leading model for stakeholder interaction in Europe, we propose consideration be given to exploring how a joint work plan; strict calendar, and/or framework to ensure a parallel platform for exchange and discussion with patient organisations and/or patient advocates is clearly articulated, implemented, and evaluated.		be considered to develop specific training (online modules or dedicated training meetings) for EU HTA processes
Ann-Marie Chapman, Lumanity	5	2. Background	Stakeholders in HTA include all of those listed but for some illness, the caregiver also has an important perspective. It is unclear to me if the term representatives might include the caregivers in this instance or whether this is covered under the phrase amongst others.		It is explained that a proxy may provide input or support a patient
Ann-Marie Chapman, Lumanity	5	2. Background	For JSC. It notes the challenges identified in this process included the need for a template for HCP input. Is the term HCP correct here as we are talking about patient involvement and HCP refers to Health Care Professional		Thank you for your comment. If needed, the final document will be clarified
Ann-Marie Chapman, Lumanity	6	2. Background	Involvement of Healthcare Professionals in JSCs and JCA/CAs – It is noted that HCPs are identified and recruited through direct contact with EU or national level organisations, the HTA Network Stakeholder Pool or direct contact with the experts themselves. Often the product manufacturer has very good connections with international KOLs so I would suggest that the submitting manufacturer is also a source of potential HCP identification. As noted most HTA bodies already including their own experts in an informal manner, complicating the involvement of a common clinical expert – If an international KOL exists, who is recognised across the geographies and is aware of potential clinical differences and their impact this might help resolve the complication of finding a common clinical expert. Transparency of when HCPs work with submitting manufacturers is a necessity for their involvement but should not stop them from participation		The HTD is welcome to circulate our online questionnaire for HCP stakeholders, but we will not ask the HTD to identify a HCP expert for a JSC or JCA. Please also refer to the COI guidance here - https://www.eunethta.eu/wp-content/uploads/2022/03/D7.5-Procedure-

					Guidance-for-DOI-and-ECA_final-deliverable-v1.0.pdf
Ann-Marie Chapman, Lumanity	8	3.1.1	For the database of patient experts and of HCPs it would also be good to provide guidance on screening criteria to ensure appropriate experts are recruited to the database		Interested experts can sign up freely to the database. A questionnaire will be developed, which asks for general information on expertise. The database will be used as a tool to identify potential experts for JSC and JCA, after which selection procedures will be applied. Please see the new section on selection process.
Ann-Marie Chapman, Lumanity	8	3.1.1 b D7.2.1.b.1	It notes 'to produce a clear guidance for assessors in how to communicate information from HTD submission, to use input from patients/ citizens. Should this be HTA submission?		As this comment is referring to the project plan, we are unable to answer or address this.
Ann-Marie Chapman, Lumanity	9	3.2.1	Within the 4th bullet point PDCA method is noted but this has not been defined within the document prior to this or after this (also noted in section 3.2.3 on the same page)		As this comment is referring to the project plan, we are unable to answer or address this
S. Walleser Autiero, Medtronic	9	243/4.1	Can it be clarified further how it will be ensured that the selection and their input in particular of patients, is representative? Also, it would be important to have a transparent recruitment process - can it be further outlined how this will be achieved?		Details have been added on the selection process. By means of including a European expert, we expect them to provide a generalizable input and thereby we assume

					their input is representative
S. Walleser Autiero, Medtronic	7	148-153	It is important that the processes for involving stakeholders are clearly defined. However, the relevant information for involvement of stakeholders in JCAs under the HTA regulation does not appear to be available in the link provided in the draft guidance document		Thank you, we will check the provided links
S. Walleser Autiero, Medtronic	7	169-170	The guidance document proposes to involve external experts with no major conflict of interest. It should be considered that in the early phases of developing an innovative medical device, the external experts with the most experience and knowledge about it might be the ones who would have worked closely with HTD to develop the innovation. Therefore, it seems counterproductive to systematically exclude these experts. Instead, a process of transparently managing conflicts of interests, and the involvement of more than 1 expert might be better suited. How many experts will be involved in a JCA is not clarified but should be.		This is detailed in section 4 of the COIC Guidance document which is publicly available on the EUnetHTA website
S. Walleser Autiero, Medtronic	8/9	229-236	It is described that patients and clinical experts would be evaluated for possible COI according to national processes. It is not clear which national processes? (of the country that the patient/expert is from?) It seems for a process in line with a EU regulation, a common process for all across countries should be identified for consistency and transparency; a country dependent process might limit standardization, consistency and in the end quality of the JCA output.		Since the process for national involvement is out of scope for this deliverable, we clarified the text.
S. Walleser Autiero, Medtronic	9	4.1	The section on identifying Stakeholders and External Experts does not specifically recognise the contribution that could be made by HTDs in helping to identify those stakeholders.		The HTD is welcome to circulate our online questionnaire for HCP stakeholders, but we will not ask the HTD to identify a HCP expert for a JSC or JCA. Please also refer to the COI guidance here -

					https://www.eunethta.eu/wp-content/uploads/2022/03/D7.5-Procedure-Guidance-for-DOI-and-ECA_final-deliverable-v1.0.pdf
Myeloma Patients Europe	2	Section 1.1	The value of patient involvement in HTA needs to be stronger and more clearly expressed in this section. The importance and direction of patient involvement in HTA needs to be set from an EU level. **We therefore suggest the following:** Separating out the description of the value of HCP involvement and patient involvement to emphasise the different but complementary perspectives these stakeholders bring to HTA. Strengthening the definition and articulation of the value of patient involvement in both the JSC and JCA. For example, using the EUPATI Toolbox definition of patient value in HTA, as agreed by the patient community. The EUPATI toolbox uses the following wording: *"Patients can provide information and insight, about the impact of their condition and treatments on their daily lives that is not available elsewhere. Patients are in a unique position to describe the outcomes that matter to them, to challenge presumptions about their health aspirations and to inform HTA processes about the potential positive or negative effects of new and existing technologies - on their health and on their ability to live and work."* **EUPATI Toolbox:** https://toolbox.eupati.eu/resources/guidance-for-patient-involvement-in-hta/ Health Technology Assessmnt International (HTAi) have also generated values on the importance of patient involvement, which represent a consensus from a range of different stakeholders including HTA bodies, academia and patient representatives. It would be helpful to directly list or reference these in this section too. **HTAI Values and Standards for Patient Involvement in HTA:**		Thank you for your comment. We will consider this feedback when finalising the guidance

			https://htai.org/interest-groups/pcig/values-and-standards/ Finally, the INAHTA position statement on patient involvement should also be used or referenced, setting out the who, when, where and how patients should be involved in HTA. **INAHTA Position Statement: Patient Involvement:** INAHTA Position Statements - INAHTA		
Myeloma Patients Europe	7	Section 2 Line 156 and Line 157	For line 156 and 157 the current wording is as follows: *"furthermore, financial support for their participation is not expected, as the incentive to get involved is to promote the position of one's own organisation."* The wording about organisational promotion is very strong and needs to be amended. For patient organisations, like Myeloma Patients Europe, the reason we participate in HTA is to represent the needs, interests, perceptives and preferences of the patients and families we represent. It is not to promote the position of our organisation or to solely serve the needs of the HTA body. In addition, for many patient organisations, whether national or umbrella organisations, participation in HTA (whether providing written or verbal feedback) takes time, effort and resource (both human and financial). As many patient organisations and patient umbrella organisations are non-profit or voluntary, we suggest that adequate financial compensation for their time and participation is appropriate. Adequately compensating these groups may improve their ability to participate and improvelevels of patient involvement.		Text has been clarified
Myeloma Patients Europe		Section 2.1.2 and 2.1	At MPE, we understand that the role of patient and umbrella organisations is as a "stakeholder". Whilst this is an important role, these types of organisations have demonstrated a vital role in HTA across Europe, including through: - Providing support to individual patients going through the HTA process. -Gathering qualitative and quantitative insights from patients and carers on their disease, treatments and perspectives to provide to HTA. -Participating directly in HTA through written and verbal submissions to		Thank you for your comment. We will consider this feedback when finalising the guidance

			represent the perspectives of patients, particularly given the day-to-day work they do with patients and their families The current guidance doesn't acknowledge the vital role that that patient organisations and umbrella organisations can play in this regard, confining them only to providing written evidence during JCA. In many European HTA bodies, patient organisations represent the collective interests of patients in HTA, instead of or alongside the individual testaments of patients. The Scotttish Medicines Consortium (SMC) in Scotland, for example, routinely involves patient organisations in this way and it is very effective. Whilst we welcome the opportunity to contribute as a stakeholder, the involvement of patient organisations and umbrella organisations should be broadened to include participation in JSC and JCA committee meetings (as well as supplying written evidence). This might be particularly beneficial in situations where finding an expert patient might be difficult (such as in orphan and ultra-orphan diseases).		
Myeloma Patients Europe	7 - 8	Section 2.2 Line 183-187	The wording in the draft guidance states: *"Where possible, individual patients with collective experiential knowledge should be targeted for contributing to JSC and JCA as external experts. These are patients with collective knowledge based on contacts and exchanges with multiple patients with experience of the condition or treatment. Patients who have been trained in scientific research and/or HTA might be able to communicate more easily with researchers and make the research process more efficient, but it should not be a requirement for patients to have had training to become involved in a JSC or JCA."* As outlined previously, patient organisations and umbrella patient organisations should be given the opportunitiy to provide the patient perspective as external experts in the process. In some disease areas, particularly in orphan and ultra orphan diseases, it may be difficult to find trained patients to participate in HTA. It might also be difficult to find trained patients in disease areas who rarely have drugs assessed through HTA.		Patient organisations and umbrella patient organisations are considered as stakeholders, and therefore, if the JCA is directly related to their disease area, they can respond to the online stakeholder questionnaire for the JCA.

			It should also be considered that expert patients with collective knowledge may only have this knowledge based upon the country they represent. More discussion and detail are needed in this consultation on how the perspectives of a range of patients will be represented in the decision-making process. Again, this is somewhere where patient organisations and umbrella organisations can play a role in representing the broader perspective and in gathering qualitative and quantitative data to support JSC and JCA. It should also be noted that the perspectives of untrained patients are equally as vital in HTA decision-making and the opportunity to seek/provide these insights should be provided in JSC and JCA processes. Whilst the topics considered in the research and HTA considerations might be complex, these should be presented effectively to patients in a way that they understand and are able to contribute to discussions. This is particularly important where patients are not trained. How patient experts will be supported through the process is missing from this guidance document but is a vital part of facilitating strong participation – for example, we consider it vital that there are specific staff dedicated to involving and supporting patients in this process.		
Myeloma Patients Europe	8	Line 188	This paragraph should also consider the topic of language. Presumably all EU JSC and JCA HTA discussions will take place in English, although this is not expressly stated in this guidance document. The guidance should also cover the process of what happens where English-speaking patients are not available. This is acknowledged later on in the consultation docuent as a longer term issue but this needs to be addressed in more detail in this specific guidance. Having patients participate who are “experts” and also English speaking may limit the types of patients able to participate and also affect the representativeness of their involvement.		Next to the EU level involvement that is described in this guidance, there are also possibilities to be involved on a national level (following national HTA body's rules and procedures), thereby not requiring knowledge of English. Section 7 of the guidance document addresses the issue of knowledge of English language in submitting input for a JSC or JCA on EU level.

Myeloma Patients Europe	8	Section 3	**<u>Confidentiality:</u>** Patient organisations and umbrella patient organisations are also effective in recruiting patients to participate in HTA and in supporting these patients to participate. HTA participation can be an unknown and worrying experience for patients and help and support can be very beneficial. For example, explaining the processes and types of questions they might be asked in a meeting and providing them with useful references and resources. Whilst not specifically outlined in the draft guidance, we ask that this type of support should be enabled in the final guidance and that confidentiality does not unnecessarily hinder the recruitment process or support patient organisations and umbrella patient organisations are able to give to nominated patients. For example, it is difficult for patient organisations and umbrella patient organisations to recruit the right type of patient without accurately knowing the drug being assessed and the disease setting. It is also difficult to support the patient when they are not allowed to discuss the meeting attendance with anyone. Exploring how dialogue between patient experts and patient organisations could be facilitated is important, whilst also protecting the commercial interests of the pharmaceutical industry.		This is stated under the section 4.1 (recruitment). In particular for JSC, caution is necessary to respect confidentiality. To be able to obtain the experience of patient organisations, in a JCA these stakeholders are invited to reply to the online questionnaire.
Myeloma Patients Europe	10	Section 4.1	Experience of MPE and its members has shown that the availability of dedicated staff to coordinate patient, public and expert involvement is vital in developing relationships, training, building databases, inviting contributions and advising/answering questions. We strongly consider this would be a valuable approach to include for the JSC and JCA. Having dedicated staff in place who are responsbilie for developing and communicating externally is important for visibility and in increasing the numbers of patient experts and patient organisations invovled in HTA.		Thank you, we agree
Myeloma Patients Europe	10	Section 4.4.1	Consider training through existing channels used by advocates and patients for knowledge: •Information and training videos for patients, which can be disseminated by patient organisations •Training through national HTA bodies, who may already have established relationships with patients •Work with umbrella organisations and their training programmes, such as EUPATI, EURORDS and the Myeloma Advocate Development Programme to develop constitute training to be give to a range of patient representatives		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance, EUnetTHA 21 participates in EMA training. Additionally,

			Consider information for different languages		the recommendation will be expanded so that in the future it can be considered to develop specific training (online modules or dedicated training meetings) for EU HTA processes
Myeloma Patients Europe	11	Section 4.2.1	Comment: To ensure that participants on the existing database are not lost at the end of EUnetHTA21, would an email to all participants asking them if they wish to be on the new database assist with GDPR requirements? We understand that GDPR may prevent this, however, it seems difficult for the permenant secretariat to start again from scratch.		The current EUnetHTA 21 stakeholder repository is not set up in a way to suit the needs of an expert database for a JSC and JCA. Additionally, EUnetHTA 21 will not have resources to set up a dedicated external database for this purpose
Myeloma Patients Europe	11	Section 4.2	Patient experts participating in a JSC and JCA would benefit from receiving appropraite and unbias information on the new medicine to support their participation. Useful information could include a summary of clinical trial data, how it might be included in treatment pathway, side-effects, advantages and disadvantages. This guidance should consider the HTAi Summary of Information for Patients (SIP) approach developed first by the Scottish Medicines Consortium and adapted for international use by HTAI patient and citizens working group. Under this approach developers submit a plain language summary or “SIP” which can be checked to ensure accuracy / non-bias, then handed to the external patients and experts as a base information to support input. It is considered best practice by patients and HTA bodies in ensuring that patient organisations have the correct level of information to participate effectively in HTA decision-making. It can be used / adapted by any HTA body and can be found here: https://www.cambridge.org/core/services/aop-		For JSC, European level patient expert will have access to the briefing book. A lay summary is not foreseen. For JCA, given the timing of European patient (expert/stakeholder) involvement, there is no data submitted by the HTD and therefore also cannot be shared with patients. After

			cambridge-core/content/view/2A17586DB584E6A83EA29E3756C37A14/S0266462321000167a.pdf/development-of-an-international-template-to-support-patient-submissions-in-health-technology-assessments.pdf		finalisation of the JCA, also the submission dossier from the HTD is publically available. Tools to aid patients are welcome and this should be considered in the future.
Myeloma Patients Europe	11	Section 4.2.2	Clearer information should be included in this section on how the stakeholder comments will be considered and taken into account in decision-making. In addition, how this consideration will be relayed back to stakeholders and whether guidance will be consulted on.		The purpose of stakeholder input for a JCA is described in Table 4.1 As per the HTA Regulation decision making is conducted at member state level and so how stakeholder comments are taken into account in decision making is outside the scope of this guidance. The JCA report will be published on the EUnetHTA website and details of stakeholder submissions will be published alongside the report. There is a separate process describing the steps and procedure for public consultation on guidance etc.

Myeloma Patients Europe	13	Line 384	A detailed written explanation of the processes outlined in the table would be beneficial. The diagram is not always clear, particularly the differences between national and EU level roles. For example, with the national role outlined in Line 384, will this always happen or is this just in relation to existing national procedures? Some HTA bodies do not involve patients in this way, what happens where HTA bodies do not have defined processes?		The contribution of the national experts should be included in the individual position. In contrast to the involvement of the European experts, the position of the individual national experts is neither presented in the JCA report nor in the final written recommendation. The involvement of the European experts is therefore important, as they may be a valuable addition for HTA organizations that do not involve experts on a regular basis. The process for national involvement is out of scope for this deliverable, the text is clarified.
Myeloma Patients Europe	16	5.1.2	Patient experts should be a standard part of the process not ad hoc. A consultation period on the draft report is needed.		It is a standard part of the process to seek patient experts/stakeholder for participation in a JSC or JCA. Their participation requires responsivity on the part

					of the organisations to ensure a timely identification of relevant external experts. As explained in section 7.1, there is no consultation of a draft JSC or JCA foreseen
Myeloma Patients Europe	20	Section 6.2	As previously outlined, for patient organisations there needs to be specific representatives in EUnetHTA and permenant secretariat responsibile for engaging with patient experts, recruitment and in answering questions.		Thank you, we agree - please see section 7. on future considerations for the HTAR
OIFE	7	182-183	OIFE wants to support this view. We believe the collective patient experience should be preferred.		Thank you
OIFE	9	Section 4.1	The Orphanet website may also be a source of recruitment.		Thank you for this suggestion, it has been added
OIFE	9	Section 4.1	General comment: When it comes to recruiting from patient organizations the focus should be on organizations that are recognized by the rare disease community specific for the condition in question. Also one should strive to recruit from organizations that have a democratic structure, in contrast to pure charities and foundations.		It is our intention to search for patient organisations that are representing patients in the indication in the JSC/JCA
OIFE	11	Section 4.2.1	General comment: Information should always be given in written form (for instance by email). It is preferable to give information verbally in addition. If it it's the first time participating in JSC or JCA it is important to have information both written and verbally.		Thank you, we have added that after verbal contact always a (summary) e-mail should be sent as a follow-up
OIFE	12	Section 4.3	General comment: It is important to give clear guidance on how input should be given and in what format (email, word document, dedicated forms etc).		We agree. We modified the following sentence under 4.2.1: When involving external experts, the secretariat will reiterate

					or explain the process and associated objectives and expectations **(including the format of the input)** either verbally or via email, or both.
OIFE	12	Section 4.3	General comment: Because of the very tight deadline, it is very important that the timeline of the process is clearly explained and the patient participating is given an overview of tentative dates and deadlines. If possible give a heads up for when one can expect to receive documents to review and a clear deadline for input.		Yes, patients and clinical experts will be informed of the timeframe and timing of participation upon recruitment.
OIFE	17	Table 5-1	General comment: Keep in mind that for rare disease patients, knowing just nationality, age and/or gender may be identifiable. It is important to clarify if this is ok with the patient depending on how much/type of personal information is shared.		Thank you, the table has been clarified
OIFE	20	Section 7	General comment: We support that a stakeholder involvement structure is set up.		Thank you
OIFE	26	Appendix 2 – Glossary of patients	Trained patient: We recommend also using the term “Real World Expert” to describe this type of patient. The terms is preferred because people with rare conditions live most of their lives outside hospitals.		Real world experts fall into the category of individual patients with experiential knowledge. We believe the definition of EUnetHTA is very clear in this respect "A person with lived experiences of the health condition. Patients can bring a detailed knowledge of the experience of living with the health condition, including its burden on daily life the

					diagnostic process, and currently available treatment(s) (if any treatment is available)." A trained patient is a patient (with experiential knowledge, collective of not) with additional training in scientific research or HTA.
Hayley Chapman, PFMD	6	1.1	Missing a clear description of the goals and aims of involving patients in JSC and JCA. HTAi's Values & Standards For Patient Involvement in HTA points to a range of values that can help -Values & Standards (HTAi): "Patients have knowledge, perspectives and experiences that are unique and contribute to essential evidence for HTA" Suggestions: -Add a statement of goal(s) or aim(s) for involving patients in JSC and JCA -This should highlight the value of understanding the lived experience of a disease within a HTA process -Patients, caregivers and patient organisations should be recognised in this statement as a source of unique expertise Also detail the methods that are to be used to reach the stated goal – so that there is a strong link between the goals and the methods used to achieve them. Suggestions: -Add a statement of the importance of high quality patient engagement, not just a token exercise		Thank you for your comment. We will consider this feedback when finalising the guidance

			-Including appropriate integration of the PFMD Patient Engagement Quality Guidance (a practical guide to planning, developing and assessing the quality of patient engagement activities and projects) will help to ensure not only strong, effective patient engagement activities but also help to strengthen patients' involvement given the quality of the engagement. The significance of integrating patient engagement and the consideration of patient experience data should also be referenced. Please see the PFMD project on Patient Engagement & Patient Experience Data Fusion and the recent publication, Schroeder, K., Bertelsen, N., Scott, J. et al. Building from Patient Experiences to Deliver Patient-Focused Healthcare Systems in Collaboration with Patients: A Call to Action. Ther Innov Regul Sci 56, 848–858 (2022). Suggestion: -Specifically, patient engagement is needed to help with the co-creation and design of Patient Experience Data and also to contextualize and add meaning to the collected Patient Experience Data. Therefore, the solution is to aim for a fusion between Patient Engagement and Patient Experience Data. -And include reference to above cited publication - "Given the collective value of understanding patient experiences across multiple stakeholder groups, we propose a more aligned approach to the collection of patient experience data. This approach is built on the principle that the patients' experiences are the starting point, and not just something to be considered at the end of the process. It must also be based on meaningful patient engagement, where patients are collaborators and decision makers at each step, thereby ensuring their needs and priorities are accurately reflected."		
Hayley Chapman,	6	1.3 Ln 140	It would be beneficial to understand the representation on the Task Group on Patients and Consumers and Healthcare. It is recommended that the following	x	The EUnetHTA JA3 Task Group consisted

PFMD			sentence includes reference to the number of patients and/or clinicians that were involved with the Task Force. "EUnetHTA Joint Action 3 (JA3) established a Task Group on Patients and Consumers and Healthcare Providers"….		of EUnetHTA members with experience in patient/HCP involvement. Two face-to-face consulting meetings with stakeholders representing European patient and consumer organizations, as well as other organizations from the HTA network stakeholder pool also took place. With regard to HCP: Two face-to-face consulting meetings with HCP stakeholders took place, one where all stakeholders from the HTA Network Stakeholder Pool attended, and one primarily with HCP stakeholders.
Hayley Chapman, PFMD	7	2.1, Ln 156	**Financial compensation**: We do not agree with the statement: "financial support for their participation is not expected, as the incentive to get involved is to promote the position of one's own organisation" This misrepresents the purpose of patient organisations, which are largely focused on supporting patients, especially with respect to accessing medicines and diagnostics. There is a considerable time and resource investment for patient organisations to submit to HTA and many do not have the capacity and resources to adequately contribute. To ensure a wide diversity of responses to any HTA it will be important that some financial compensation is provided or at		It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting compensation procedure and rules for experts participating in a JSC and/or JCA

			least offered. Moreover, patient organisations offer expertise and expert advice and therefore the value of this contribution must be recognized. They ought to be valued in the same fashion as other contributors and not be subject to discrimination or inequality in comparison to other stakeholders. SEE PARADIGM GUIDING PRINCIPLE #8: Financial Compensation and Reimbursement of Expenses: "Patient advocates deserve a reasonable financial compensation for their time and contribution when acting in advisory roles, consultancy, speaking roles or other collaborative work with third-party organisations or institutions." SEE PFMD "Global Principles for remunerating the patient community for interactions with the pharmaceutical industry": 1.1 Right to Renumeration "It is appropriate that Participants are remunerated for their experience, contribution time, and expertise." and 2.4 Fair Remuneration "Remuneration for services should be reasonable, appropriate, and represent the fair market value of the legitimate and necessary services provided, considering complexity of tasks, expertise required and training, total amount of time invested, urgency, country of origin, local regulations, and other contributing factors". While the scope of the quoted Principles pertains to interactions withn the pharmaceutical industry, PFMD believes that these fundamental principles should be recognized and patients should be fairly remunerated for their time and, expertise during any stakeholder engagement. This will help to increase transparency and fairness in remuneration approaches, and build trust and respect between stakeholders. Remuneration and expenses reimbursement should be aligned with other European institutions (ie EMA, EU Commission).		
	13	Table 4-1	1: - Information needs to be provided to those you want to involve on the aims of patient involvement in general as well as the specific aims for their		Thank you for your observations, we

			involvement in this HTA. 2: - Additionally, information needs to be shared with them on the other stakeholders involved (e.g. clinicians) and their respective roles To achieve the above, a clear and understandable framework on the HTA process, the stakeholders involved and how this is considered for the recommendation will be very helpful. Clear patient engagement expectations that demonstrate the need for true patient collaboration supported by data, in order to avoid any type of tokenism or "ticking the box" approach, should also be articulated. For Joint Clinical Assessments (JCA): The document makes it unclear if there is an interim report that can be commented on by the stakeholders who have given input.		largely agree and will provide an info for what the process looks like and hope this will support some of statements you've made As explained in the guidance, there will be no consultation on draft
CPE	6 7 10 13 16		It is essential to state a clear goal for the patients involvement. HTAi's Values and Standards for Patient Involvement in HTA (2014)https://htai.org/patient-and-citizen- involvement/ state that 'patients have knowledge, perspectives and experiences that are unique and contribute to essential evidence for HTA'. For this reason, the document should contain: - A clear and distinct statement of goal(s) or aim(s) for involving patients in JSC and JCA which articulates the value of lived experience as a source of expertise and a unique contribution that can be made by patients and their representatives such as carers and staff/volunteers of patient associations. Patients and their advocates involvement should not be blended with the aims of involving health professionals who bring a different expertise. - A clear framework setting out the who, when, where and how (methods and approaches) guided by the goals to increase the likelihood of patients involvement to be meaningful. We recommend INAHTA's position statement on patient involvement (2021) as a useful guide. Note also HTAi's quality standards for general HTA processes, especially the need for reflection and review to allow continuous improvement. Financial compensation: The statement: "financial support for their participation is not expected, as the incentive to get involved is to promote the		This comment was difficult to read and connect to specific sentences. We tried to address the major themes of the comment. Additional information is given on the value of patient involvement. the procedures are detailed and explain the different timepoints (for JSC and JCA) in which experts or stakeholders can be

			position of one's own organisation" is not correct. The sole interest of patients to be involved in the HTA process is to protect the interest of other patients, not to promote the position of the association they belong to. Thus, especially when the patients or their representatives are volunteers within the association and not employed by the association, their effort to participate in the HTA process must be paid and their live expenses reimbursed. Otherwise, a barrier is created to an equal access even within the HTA process itself. This is also stated in the PARADIGM (2021) guiding principle #8 Financial Compensation and Reimbursement of Expenses: "Patient advocates deserve a reasonable financial compensation for their time and contribution when acting in advisory roles, consultancy, speaking roles or other collaborative work with third-party organisations or institutions." The rationale to prefer individual patients to patient representatives or patient advocates is not clear, especially in the JCA. A framework with clearly defined roles and criteria might help to clarify this point. Currently, it is unclear why the ability of patient associations to bring a broad range of knowledge and experiences to the JCA would be limited to written submissions which do not allow for the dynamism of the discussion in the committee. We note the definitions and suggest also considering Street J, Stafinski T, Lopes E, Menon D (2020). Defining the role of the public in Health Technology Assessment (HTA) and HTA-informed decisionmaking processes. International Journal of Technology Assessment in Health Care 1–9. https://doi.org/10.1017/S0266462320000094. This sentence puts the pressure on patients to acquire scientific knowledge to participate. This expectation from HTA bodies may be a barrier to participation and will not help HTA researchers to incorporate experiential knowledge by making non-scientific voices less legitimate and therefore, less heard HTA researchers could profit more from another approach. Our suggestion: "Facilitations skills and training in participatory methods can help those who conduct EUnetHTA 21 JSC and JCA to make the process more fruitful and efficient" It is essential that patient experts and their associations taking part in JSC and JCA receive appropriate information to support their effective contribution. Developers should submit a Plain Language Summary or Summary of Information for Patients which can be checked to ensure content is accurate and non-promotional, then handed to the external patients and experts as a base line information in addition to the specific information from the overall package. This will be essential to receive a qualified input from the patients. What measures will be taken to ensure that		included. It also is specified that the expert will always be offered an introductory call to help them understand the process and answer any questions they may have A recommendation is remuneration of experts involved should be explored in the future, this is out of scope of the current document We better defined the selection criteria.

			this registration is accessible to all to promote fair access to the HTA process? Currently the promotion of the registrations is limited to those already connected to EUnetHTA. HTAi's Values and Quality Standards state that 'patient involvement processes address barriers to involving patients in HTA and build capacity for patients and HTA organizations to work together. In the stage of transition, it should be possible to contact the people in the EUnetHTA21 database and motivate them to register in the future database / registry. (1) Before being involved, patients and patient experts need to be informed on the aims of the patient involvement for their specific involvement and this information should be aligned and clear for all stakeholders. (2) They should also know what type of patient / clinical stakeholders are involved for what purpose; potentially, how the input is intended to be used / implemented		
Hayley Chapman, PFMD	12	5.2.1	(3) They should get an overview (simple) on the respective HTA process and where in the process their contribution will play a role Joint Clinical Assessment (JCA): What kind of information will be taken into account and how? Will there be a consultation of the report, where patient experts / stakeholders can react? Page 16; 5.1.2 JCA / EU Assessment phase: Patient experts should be standard not ad hoc. Their consultation on the draft report should be included.		On page 11 we outline the following: When involving external experts, the secretariat will reiterate or explain the process and associated objectives either verbally or by email, or both. Patient and clinical expert are systematically included. The term "ad hoc" is deleted as it could be misleading. It merely implies that relevant questions that arise during the procedure can and should also be asked. There is no consultation on the

					draft report as such planned.
Roche	General		While we acknowledge that EUnetHTA 21 Service Contract does not follow the same legal framework as the HTAR (as it does not apply yet), to avoid confusion, clear and separate statements should be made in all instances about what is going to be the process under EUnetHTA21 and what is EUnetHTA21's recommendation for future JCAs and JSCs to be carried under the HTAR (whether it is the same or different, and the respective reasoning behind such recommendations) or a separate document or appendix with the recommendations from EUnetHTA 21 to the Coordination Group for future JCAs and JSCs under HTAR should be developed.		Thank you. If something in the document is specific for EUnetHTA 21 this is specified as such.
Roche	General		There is a need for clarification in this guidance about the differences between Stakeholders and External Experts in terms of: ● Selection criteria and selection process ● Access to documentation ● Conflict of interest frameworks ● Confidentiality agreements differences ● Level of acceptance of their feedback in the decision making process ● Scope (e.g. Are external experts only involved JSC and JCA or also on methodological guideline? Page 7, line 162-163, then if further processes than JSC and JCA are in scope of this guidance, a template for the input would be needed) ● Financial compensation Roche suggests that there should not be any difference made between Stakeholders and External Experts as they all are individuals that can sign confidentiality agreements to be able to participate to both JSC and JCA. Roche considers patient and HCP organisations' input of high value as they provide community knowledge and consensus which may not exist on an individual level.		More clarity will be given on the definition of stakeholder and experts.
Roche	General		The guidance states that medical associations can only participate in JCA, but not in JSC. Looking at many national processes the process may be quite the contrary with medical associations commenting early on, providing robust input based on guidelines they develop. Roche considers patient and HCP associations' input of high value as they provide community knowledge and		In the stakeholder roundtable we have held, HCP stakeholders have mentioned they are not able to provide

			consensus which may not exist on an individual level. Roche suggests that Stakeholders sign a confidentiality agreement to be allowed to participate to JSC.		a consensus view given the numerous personal opinions in the field. This would be even more complex if they cannot share information with all their members.
Roche	General		There is reference made to local HTA process involvement, but no guidance if providing local feedback then leads to either continued involvement at EU HTA level or on the contrary will lead to exclusion from EU level involvement. Roche proposes that (especially for smaller indications) patients & HCPs should be able to comment / be included both on local as well on EU HTA level.		In addition to the EU-level participation described in this guidance, there are also opportunities for participation at the national level (according to the rules and procedures of the national HTA bodies). However, the contribution of the national expert consultation should be included in the individual position at the discretion of the respective HTA body.
Roche	7	147 (in conjunction with 191-193 and 201-204)	We understand that Stakeholders is meant in a broader sense and refers to the organisations/associations, while External (Clinical) Experts and Patients refer to the individual person. What is not yet clear is the interplay and overlap of the different roles. Can these roles be performed in parallel or does one exclude the other? Specifically, it raises the following questions: -According to 192-193, a Patient can also provide input as a Stakeholder representing the interests of their organisations in a JCA. Would this exclude him/her as an External Expert in a JCA? If a patient organisation is involved as a Stakeholder, can its members still be		Thank you, the definition for both stakeholders and experts have been clarified in the document as have their roles.

			engaged as External Experts in a JCA? -According to 203-203, a healthcare professional can provide input as a representative of his or her organisation. Can the healthcare professional be involved in parallel as External Expert and Stakeholder in a JCA? Does the participation of his or her organisation as a Stakeholder exclude him or her as a External Expert?		
Roche	7	148-158	As stated in the general comment, it should be made clear what are the selection criteria that define Stakeholders and External Experts. NB: Patient's definition should be broad (expert patients or caregivers with own experiences and ready to represent the community experiences in order to ensure relevance)		Thank you for your comment. The differences between stakeholders and experts has been clarified. The "criteria" for their selection will be made more clear as well.
Roche	7	183	"Contributing" - maybe it can be made clearer about the different roles Patients (wide definition) can have, e.g. that it is for consultancy, advisory as well as joint decision-making		Thank you. Additional details are provided in the definition section; The purpose of each time point is in table 4.1. and the responsibility of outcome report lies with assessor/co-assessor, not external experts
Roche	7	156-157	Financial support for Stakeholders participation is not expected although producing meaningful feedback for JSC and JCA requires strong preparatory work. Roche suggests to provide the same financial support for Stakeholders as for External experts as, based on our interpretation of what we understand are the differences between stakeholders and external experts (as this is not very clearly defined), their inputs are equally valuable.		It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting

					compensation procedure and rules for experts participating in a JSC and/or JCA
Roche	7	169-171	It's unclear how major conflict of interest will be managed under HTAR as only the EUnetHTA21 policy is cited here. It should be further specified.		This is detailed in section 4 of the COIC Guidance document which is publicly available on the EUnetHTA website
Roche	7	170-171	External experts should receive financial compensation for the time investment and expenses. This financial compensation should follow clear and equity based rules of reimbursement to be fair and treat experts equally, i.e. same levels/no differentiation between payment fee for medical or patient experts. EPF (European Patients Forum) statement*: "appropriate remuneration for patients' expertise and resources to ensure participation of patient organisations needs to be ensured in the budget foreseen for the HTA framework. Not to do so would relegate patient involvement to a tokenistic level." - 2018 *https://www.eu-patient.eu/globalassets/policy/hta/epf-position-statement-on-hta.pdf		It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting compensation procedure and rules for experts participating in a JSC and/or JCA
Roche	7	182-183	Roche agrees with the position that patients with collective experiential knowledge should be targeted and wonders if patients organizations wouldn't be perfectly positioned to fill this requirement. As stated in the general comment, by including selection criteria in the definition of Stakeholders and External Experts, it would be made clear what are the differences between the two. In line with the EPF statement, Roche suggest: "The criteria for selection of stakeholder organisations for the network should be aligned with other existing criteria, such as the EMA eligibility criteria for patient and consumer organisations", 2018 https://www.eu-patient.eu/globalassets/policy/hta/epf-position-statement-on-hta.pdf		Thank you for your comment. The differences between stakeholders and experts has been clarified. The "criteria" for their selection will be made more clear as well. One thing to keep in mind (and this is hopefully more clear in the final document) is

					that individual experts, unlike stakeholder organisations, must sign a confidentiality clause and may be excluded based on their declaration of interests. The confidentiality form allows them to comment/respond to questions on topics that are not available to stakeholders
Roche	8	186-187	Roche recommends to offer training possibilities for patients/patient organisations who want to participate in JSC/JCA		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per the recommendation in the guidance, EUnetHTA 21 participates in EMA training. Additionally, the recommendation will be expanded so that in the future it can be considered to develop specific training (online modules or dedicated training meetings) for EU HTA processes
Roche	8	207-213	As stated in the general comment, it is not defined which group of Stakeholders and External Experts have access to which information and		Thank you for the comment. This section

			documents. This should be finally defined and should be clearly shown. In addition, consideration should also be given to giving Stakeholders access to certain information and receiving valuable input (likewise with signing a EUnetHTA21ECA form). Roche also proposes that clarity be provided on CCI protection under the HTA-R.		of the document has been modified.
Roche	8	222-228	Information regarding the COI Committee is given for EUnetHTA21 but not for HTAR and further information on the handling of COI is only given for HTAR but not for EUnetHTA21. A description of the full process and the handling of COI is needed for EUnetHTA21 as well as for HTAR in the future.		Thank you for your comment. The COI process under the HTAR is the responsibility of the EC, therefore, we are unable to address this in more detail in the guidance.
Roche	9	241-242	What does it mean *"the team is unable to obtain this input"*? Clearly defined rules are necessary for the process of identifying stakeholders and external experts and when it is not possible to find adequate input. It seems to be a very variable process if the team only has to add an explanation why it was not possible to include adequate input form stakeholders and external experts. As the explanation won't be assessed by a committee, the process won't be transparent.		Text has been clarified
Roche	10	264-269	Awareness of HTA opportunities for involvement communicated at scientific congresses bias the number of people to participate. Only a select few patient/groups are able to attend congresses and post-covid even fewer are attending face to face. Roche recommends additional methods of dissemination of information to a broader audience with support of the patient community. It would also be valuable to ensure that underserved and underrepresented patient populations will be represented.		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance, EUnetHTA 21 participates in EMA training. Additionally, the recommendation will be expanded so that in the future it can be considered to

					develop specific training (online modules or dedicated training meetings) for EU HTA processes
Roche	10	288-290	It is stated that GDPR will not allow EUnetHTA21 to transfer information from the patient database to the permanent secretariat. It is not clear why GDPR would not allow this and what this refers to. The processing of data requires a legal basis. Consent can be a legal basis. Would it not be possible to ask the patients to consent to a transfer to preserve the information and/or also agree to the consent of the permanent secretariat?		The current EUnetHTA 21 stakeholder repository is not set up in a way to suit the needs of an expert database for a JSC and JCA. Additionally, EUnetHTA 21 will not have resources to set up a dedicated external database for this purpose
Roche	15	388 -389	As stated in the general comment, the Identification & Recruitment phase should describe the process and selection criteria for Stakeholders and External Experts.		A section has been added to clarify the selection process of external experts
Roche	16	410-411	''*International consensus-based guidance for the reporting of patient and public involvement in health and social care research (GRIPP2)*'' are used by EUnetHTA21. It should be specified what is the relevance of this guidance under the HTA-R or if and how this guidance will be substituted by something else.		Thank you. The GRIPP2-SF will not be used directly in the JCA or JSC reports but rather will be used to inform the contents of the JCA and JSC report templates. These templates are still in development.
Roche	18	419	In terms of results of the patients and clinical expert involvement, we suggest providing all the comments from Experts and Stakeholders on top of the consolidated summary.		It is intended to publish stakeholder submissions and

					European expert input received via their respective input templates. Personal information will not be published, In the case of stakeholder details of funding will be provided.
Roche	21	488 - 492	Templates may need translation into lay language and other official EU languages. It is not clear if EU HTA will also translate HTD documents or parts of them (like briefing books etc.) and make these available in lay language and/or other official EU languages than English.		Next to the EU level involvement that is described in this guidance, there are also possibilities to be involved on a national level (following national HTA body's rules and procedures), thereby not requiring knowledge of English. Section 7 of the guidance document addresses the issue of knowledge of English language in submitting input for a JSC or JCA on EU level. Specific documents (outside the templates) are not foreseen to be translated
Roche	21	497-505	There is a high level discussion on the geographical spread for the involvement of patients and clinical external experts, but no concrete guidance or recommendation is provided. Roche suggests having 2 external experts from different countries for each		Since we are aiming to involve experts with collective knowledge, that can represent a

			category of patients and clinicians to be representative of EU. There are cases though where it might not be possible (i.e. rare diseases). Also, when EU external experts are not available, experts outside EU should be allowed.		community broader then their member state, we have taken out the selection criteria on geographical spread.
Roche	21	494-496	Caregiver input should be made possible through a separate template in general, not only when they are a proxy.		Thank you, the sentence was amended to show that either additional questions dedicated to caregivers should be included or a separate template should be created.
Marko Ocokoljic (SIOPE)	7	156, 157	Furthermore, financial support for their participation is not expected ***but highly engouraged.*** ~~as~~ ***Nevertheless,*** the incentive to get involved is to promote the position of one's own organisation.		It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting compensation procedure and rules for experts participating in a JSC and/or JCA
Marko Ocokoljic (SIOPE)	21	471, 472	Training opportunities for patients and healthcare professionals together with EMA should also be considered to inform about HTA activities and possibilities to engage in HTA processes. ***This is especially important in rare disease settings and paediatrics***.		In EUnetHTA 21, there are no resources available to develop training for experts and stakeholders. However, as per recommendation in the guidance, EUnetTHA 21

					participates in EMA training. Additionally, the recommendation will be expanded so that in the future it can be considered to develop specific training (online modules or dedicated training meetings) for EU HTA processes
IPPOSI	**6**	**119**	We suggest amending this wording to "Patient and healthcare professionals provide important knowledge about the disease, treatment processes, treatment outcomes, adherence issues and unmet medical need." - this wording indicates the additional areas they contribute to, and emphasizes that not only they "can", but that they "do" provide such knowledge. There are several other places in this section where "can" is used, which could suggest something is optional. The necessity of patient involvement at both the EU and member state levels should come through in all the language used. This is in line with the language used in Articles 11.4 (JCA) and 18.6 (JSC) of the new HTA Regulation.		Thank you for your comment, we have re-written this section
IPPOSI	**8**	**206 – 218**	We agree that confidentiality is critical in the process. The confidentiality section makes it very clear that documentation and communications are kept secure and that the JCA report remains confidential until published.		Thank you.
IPPOSI	**8**	**206**	We recommend that EUnetHTA takes the initiative to have a separate section to address confidentiality for stakeholders involved (in this case, patients and healthcare professionals). This section will help outline how information provided by patients, patient advocate groups, clinicians and other healthcare professionals will be stored safely, and not be released without further permission. These additional details will ultimately promote trust, engagement, and involvement in HTA.		Thank you for your comment. In our guidance, we follow the requirements set out in the HTA Regulation. To facilitate transparency, it is important to publish all input received from patients and clinical experts
IPPOSI	**8**	**229-236**	We underline the importance of supporting high quality national processes to		Thank you. We

			evaluate possible conflicts of interest among proposed patient experts and clinical experts (in line with EUnetHTA Guidance) in order to avoid differing interpretations across the region and introducing any suspicion or mistrust among Members. It could be helpful to include the details of how national compliance (or non-compliance) with the Guidance is monitored, and addressed.		acknowledge this; however the national level input is out of scope of the HTAR.
IPPOSI	**8**	**229-236**	We believe it is important that all DOIs be made publicly available, and that the mechanism to do this be created on the EUnetHTA 21 website as a priority.		Thank you. This will be done under the HTAR, but not fully within EUnetHTA 21 due to differing rules in the MS.
IPPOSI	**9**	**243 – 367**	We agree that the process of recruitment of stakeholders and external experts and further involvement should be clear and appropriate. We believe that membership of the HTAR Stakeholder Network should remain open indefinitely - building trust and facilitating a diverse pool of stakeholders and external experts to continuously enter the health technology assessment space.		Thank you. We do not disagree, but this will ultimately be decided by the Coordination Group and the European Commission.
IPPOSI	**9**	**243 – 367**	We suggest that where possible efforts should be made to launch public calls for participation in JCAs on a dedicated webpage to allow patients and their representatives to regularly visit the site and self-nominate. A list of opportunities could also be circulated to a self-subscribing mailing list.		Thank you. We agree. This is planned and this was done during JA3. It ought to be easier under the HTAR as the annual workplan will be published by the Coordination Group.
IPPOSI	**9**	**243**	We recommend EUnetHTA considers adding a separate section at the beginning of Section 4 - Process - where considerations about diversity, equity, and inclusion are emphasized. We believe that the process of stakeholder engagement should not only lay out the technical process of engagement, such as timing, documentation and dissemination, but rather advocate an open, transparent, diverse, inclusive and equitable environment throughout the engagement process.		Thank you for your comment, we have included a recommendation dedicated to inclusiveness.
IPPOSI	**9**	**243**	We recommend that an evaluation of the diversity of the patients and representatives contributing to JCAs should be conducted annually.		Thank you. We received a similar comment from Eurordis

					and have included that a detailed annual reporting of patient involvement will be done and published including some of these details.
IPPOSI	**9**	**244**	Emphasizing that the process is transparent will facilitate information sharing among key stakeholders. We believe having a section to address the inclusive and friendly environment will make sure all parties in the HTA process be respectful and accountable for their activities.		Thank you for your comment. We agree that these aspects are important, but we believe these are standard practices
IPPOSI	**11**	**313-317**	You may already be aware that EUPATI maintains a network of patient experts. It may be worthwhile for EUnetHTA to include a reference to EUPATI Connect (https://connect.eupati.eu) and liaise with EUPATI to investigate an efficient way for patient experts to be included in the database.		Thank you for this comment. Yes, we are well aware of EUPATI and have had patient experts who were graduates of their program involved in past EUnetHTA work.
IPPOSI	**11**	**319**	It would be useful to provide an explanation of how the data are preserved and kept. A flowchart may be useful for describing the process covered in the SOP.		There is a brief section detailing what information should be outlined in a SOP, and it covers data storage and maintenance. This will be done by the future structure
IPPOSI	**12**	**372**	Typo (for JCA and JCA) presumably (For JCA and JSC)		Thank you
IPPOSI	**13**	**384**	It would be worthwhile to collect data on unmet medical needs when collecting stakeholder information.		We added a definition of a patient advocate, based on the definition

					of an advocate in the HTAi Glossary. "Patient advocates speak on behalf of a patient organisation. They are closely involved with patients and are able to voice any concerns and views of a patient group."
IPPOSI	**16**	**393**	The fourth bullet point in the scoping process section refers to the potential for clinical expert input. However, it makes no specific reference to the potential for patient expert input - even though page 13 line 384 seems to indicate that there is potential for both clinical and patient expert input at this stage. This needs to be amended.		Thank you – the figure has been updated
IPPOSI	**16**	**393**	The language used in the EU assessment phase appears quite vague in terms of its commitment to involve patients. We suggest that the term 'the ad hoc involvement of 'european' expert' be improved for clarity purposes and the term patient expert should be included.		Thank you for your comment, we have updated the text.
IPPOSI	**16**	**406-407**	We suggest amending this sentence to "… to adequately reflect patient and healthcare professional involvement the method and timing of involvement, as well as the extent to which patient and healthcare professional influenced the JSC or JCA overall, should be described in the JSC or JCA report." We realize the inserted phrase is mentioned in the table, but feedback on the results of patient involvement has often been neglected in the past and should be emphasized here.		Thank you for pointing this out. This section has been re-written.
IPPOSI	**19**	**429**	We would support some transparency around the evaluation of patient involvement and we would recommend that an annual report include aggregated data from the stakeholder and expert questionnaires.		Thank you. We received a similar comment from Eurordis and have included that a detailed annual reporting of patient involvement will be done and published

					including some of these details.
IPPOSI	**21**	**506-511**	We believe that much greater consideration needs to be given to HTAR Article 11 which calls for the involvement of patients and other experts in the assessment process. We believe a more robust patient involvement framework is needed for the assessment stage of the JCA process. At a minimum, we consider it appropriate that a number of patient experts attend and observe the process of drafting the JCA report. This could be taken a step further whereby 1-2 patient experts could be invited as co-assessors from the start and invited to follow the process from beginning to end. We would also consider it appropriate that the draft JCA be open to comment from patient experts and stakeholders for a period prior to publication. The final JCA report would detail how any feedback during this consultation period was considered.		The ultimate interpretation of Article 11 will be done by the HTAR Coordination Group.
IPPOSI	**22**	**513-514**	We agree a process to support and encourage national expert and stakeholder involvement should be set up. Patient Involvement experiences vary across Member States and it is important that we start to harmonise this where we can to avoid inequalities around opportunities to input and participate.		Thank you.
IPPOSI	**25**	**539**	Appendix 2 - Patient Representative and Patient Organization are defined- and are listed in the first summary paragraph. but patient advocate (listed 3 times throughout the guidance) is not defined in the glossary anywhere. It would therefore be helpful to provide a definition for patient advocate or include patient advocate in the patient representative's definition.		Thank you, this is added

Comment from	Page number	Line/ section number	Comment and suggestion for rewording **D7.3 Template for patient and clinical expert input** **Patient organisation/stakeholder input template.**	Editorial comment?	HOG answer
Bayer	4	71 (question 12)	The approach in gathering evidence is not being systematic enough, should be replaced by more systematic methodologies that allow to validate input and reduce the uncertainty e.g. group discussions, Delphi, patient preference, direct involvement.		The aim of the patient input via this template is to gather views and experiences from patients via direct input. A systematic gathering of evidence would need some significant resources and might be done by HTAbs on national level. However in the patient input template, they can state the sources where and how they gathered their input (see page 3, line 63). This is further described in the guidance.
European Patients' Forum	1	13	To add: "*They can also foster a space for co-creation with patients in the study design phase*"	x	The stakeholder template is not dedicated to Joint Scientific Consultations (JSCs), therefore the suggestion was not implemented.
European Patients' Forum	1	24	In some instances, there might be useful to collect information on the burden of treatment, if it has strong undesirable side effects.		There is already a question under Section "Experience with currently available therapies/health

					technologies" about "the burden of therapies…"
European Patients' Forum	2	58	Some patients' organisations are "umbrella" and do not represent specific conditions/disease-groups. There should be an option for this.		Thanks, we modified the question to " please state the health condition(s) represented by the organisation **and/or the remit of the organisation"**
European Patients' Forum	3	63	Substitute "where" with "how	x	The templates did undergo medical editing and no change was requested.
Dr Rosa Giuliani, European Society for Medical Oncology (ESMO)	1	4-9	"In order to ensure the inclusiveness and transparency of the joint work, the Coordination Group should engage and consult widely with stakeholder organisations with an interest in Union cooperation on Health Technology Assessment (HTA) as early as possible in the processes, including patient organisations, healthcare professional organisations, clinical and learned societies, health technology developer associations, consumer organisations and other relevant non-governmental organisations in the field of health."		Thank you, we agree and consider our guidance reflects this
Matias Olsen, EUCOPE	General		The guideline provides a thorough description of the process of patient and HCP involvement in EUnetHTA deliverables; however, it should be emphasised how patient contributions can effectively be integrated into the decision-making process. For this purpose, patient involvement should always allow active participation of patients or their representatives during the appraisal, and not be limited to a mere collection of inputs through the template. It should also be stressed/clarified in the text (for example in paragraph 4.2.1) that the procedures of patient involvement		We appreciate your comment, nevertheless it is out of scope of this document which deals with expert and stakeholder involvement in JSC and JCA. Appraisal comes at a later stage and is done on a national level.

			presented in the document will be followed routinely for all products and not on a case-by-case basis. Finally, we were not able to identify in the document how the input from experts and/or stakeholders will be weighted in the overall report. Are the insights going to be taken into account according to specific criteria, or will they be considered as general information to be included for the Assessors?		
Matias Olsen, EUCOPE	7	170-172	External experts should as a general rule be compensated for the time invested in their contribution, to ensure sufficient participation of relevant experts. The offer of compensation should have an element of discretion, with regards to the appropriate amount which is reflective of the time invested, and experts ability to accept financial compensation, as some might not be able to accept financial compensation for varying reasons.		It is not budgeted within EUnetHTA 21, but the guidance reflects a recommendation that the HTA Coordination Group needs to develop a guidance reflecting compensation procedure and rules for experts participating in a JSC and/or JCA. Furthermore, not every expert may be able to accept compensation (e.g. due to national laws).
Matias Olsen, EUCOPE	8	191-193	Please provide the rationale explaining why patients can also provide input as stakeholders representing the interests of their patient's association only for JCA, and not for JSCs.		We believe this is explained in the D7.2 guidance document. In summary, we believe it is not possible for JSC to open up to stakeholder input due to confidentiality
Matias Olsen, EUCOPE	10	290	Could there perhaps be one shared database for both EMA and the EU HTA procedure to avoid duplicating resources? It would ensure experts and organisations only have one database to subscribe to, minimising potential confusion and reducing the		Thank you for this suggestion. The alignment with the EMA database is out of scope

			barriers for participation.		for this guidance and is for future decision under the HTAR CG and the EC
Matias Olsen, EUCOPE	12	372-373	Please clarify the meaning of "complementary information". It is important to ensure a meaningful participation of patients and clinicians in the EU HTA procedure, and patients' inputs and perspectives should rather be the core of JCAs/JSCs together with clinical data and methodological considerations.		Thank you for your comment. We have clarified in the text that external expert and stakeholders involved, do have an important role in help providing context for the data submitted. External Experts also can be involved during the JSC and JCA, by answering specific questions the assessors and co-assessors may have.
Matias Olsen, EUCOPE	13	383-384	If the patient input template is to be utilised so far in advance of the JCA scoping, then it is unreasonable to ask patients/stakeholder organisations for input without providing background information on the treatment, its target populations, administration, and effects.		As we are interested in understanding patient's experiences with living with the disease/condition and expectations for a treatment, we do not think this information is crucial. For HCP, this is similar.
Matias Olsen, EUCOPE	13	383-384	There is currently no description or references on the appropriate number of experts to include for a given assessment. It could be helpful to provide at least a range of the number of experts and stakeholders that should be strived for, to involve in each activity. When it comes to expert and stakeholder "Input during PICO		Thank you for your comment. First, involvement on the national level is outside the scope of the HTAR and therefor also this

			development at National level", the guidance document should provide national agencies with clear endorsement of expert and stakeholder involvement and directions for this type of activities. Further, it is not clear from the document the extent to which this is currently the case at Member State level, and further clarification and description could increase the uniformity and improve the positioning of described activities that remain the competency of national agencies, with the future EU HTA procedure.		document. It is mentioned only in order to provide an idea of where this could take place.
Matias Olsen, EUCOPE	15	388-389	Please clarify why patients are not routinely invited to face-to-face meetings with HTD, HTA bodies and EMA.		Patients participating in a JSC (i.e. at the European level) are routinely invited to participate in the face to face meeting with the company.
Matias Olsen, EUCOPE	16	400-403, 418	For transparency purposes, all stakeholders involved in the assessment need to be disclosed in the public domain.		Thank you, this is what is stated in the text. Their input will be published alongside the final JCA report.
Matias Olsen, EUCOPE	21	473-484	An additional point of consideration is whether the information stored in the database (e.g. patients insights and expert contributions) can be leveraged for future HTA procedures, and if so, the manner in which this will be done.		Thank you for your comment. This will be up to the Commission to decide when setting up their database. Our initial idea was not to include patient input, but rather information on their expertise area(s) and contact information as well as maybe tracking the products they have been involved in."
ISPOR – The Professional Society for	3	66	We suggest adding a question about how the disease affects the quality of life of patients. We recommend including a VAS scale.		The questions implicitly and explicitly (see page

Health Economics and Outcomes Research					6) ask for quality of life of patients.
ISPOR – The Professional Society for Health Economics and Outcomes Research	General to both templates		The templates provide a thorough introduction and overview, and the questions include detailed prompts. This can be very helpful to users, but it may be worthwhile to consider the tradeoff between detailed prompts and user-friendliness.		Thanks we will do so. Clarification was added to the templates.
ISPOR – The Professional Society for Health Economics and Outcomes Research	General to both templates		For the "Impact of the condition" section, it is notable that the term "quality of life" is not used. This may be worth adding to the prompts.		The questions implicitly and explicitly (see page 6) ask for quality of life of patients.
ISPOR – The Professional Society for Health Economics and Outcomes Research	General to both templates		It would be helpful to provide a clear statement on the template regarding the confidentiality of information collected.		The patient organisation/stakeholder input template is only for JCA (not JSC). We do not ask for any confidential information in the template, therefore no confidentiality agreement is needed. Furthermore, we do not release any contact details of the person that completed the template. We will make sure that this is clear in the template.
ISPOR – The Professional	General to both		Informing individuals how all the information collected from the template will be used would be beneficial. In particular, the		Thanks this will be clarified in the template.

Society for Health Economics and Outcomes Research	templates		inclusion of the summary section ("Summary and key messages") without additional information may raise concerns that only this section will be used or will be of primary interest.		
Natacha Bolanos, Lymphoma Coalition	9	4.1	**Models to support recruitment and engagement** The systematic recruitment of stakeholders and external experts is of paramount importance to health technology. We firmly believe the inclusion of European medical societies (using channels such as the EUnetHTA 21 Stakeholder Repository and HTAR Stakeholder Network) as well as the involvement of other agencies or entities with interest in this area (such as the European Reference Networks and European Medical Association) is equally paramount to the advancement of health technology. While we highly value the strengths of the different models of consultation, collaboration, and engagement (including those employed above) to guide and support expert recruitment and stakeholder expertise, we wish to express our anticipation that an inclusive process will naturally extend beyond immediate stakeholders to ensure a comprehensive, inclusive, and sustainable model of engagement in health technology is implemented.		Thank you for this comment and we largely agree. In D7.2 (guidance document), we have explained our process for recruitment
Natacha Bolanos, Lymphoma Coalition	12	379-380	**Consideration of important "lessons learned"** In our review of the documentation, *"The described approaches and procedures for external expert and stakeholder involvement may apply both to EUnetHTA 21 and under the HTAR"* caught our attention due to a perceived lack of clarity. In our view, this phrase may imply the intention to leave space for national HTA bodies to follow and/or implement deviating approaches. As we anticipate there will be important "lessons learned" as EUnetHTA 21 evolves and reaches significant milestones and/or deliverables, we propose this phrase be		Thank you for your comment. The work of EUnetHTA 21 will have to be reviewed and amended to be fully aligned with the mandate under the HTAR, and this is the task of the Coordination Group

			revisited and/or reframed to clarify the meaning further. Namely, whether the intention is to leave space for adjusting HTAR processes according to key "lessons learned" from EUnetHTA 21 or not.		
Natacha Bolanos, Lymphoma Coalition	13	4.4	**PICO development** In *Table 4-1: Overview of external expert and stakeholder involvement in EUnetHTA 21 productions"* namely the second row, "*Input PICO development at National level",* we are concerned about leaving expert and/or stakeholder involvement as a national requirement. Although we fully understand the need for considerations at the national (procedural) level while concurrently supporting the EUnetHTA 21 core objectives, this phrase may present challenges should PICO development not be harmonized at the European level to the extent that is possible and/or feasible.		Thank you for your comment. The table has been revised for the final version. Please note however that involvement on the national level is outside the scope o the HTAR and therefor also this document. It is mentioned only in order to provide an idea of where this could take place.
Natacha Bolanos, Lymphoma Coalition	13	383-384	**Consistent terminology, language and guidance** To promote and ensure accurate interpretation, the use of consistent terminology, language and/or guidance between documents is essential. As such, on page 7, lines 179 to 181, that it states *"In order to ensure consistent use in all HTA outputs, the terms "patients", "patient representatives" and "patient organisations" are clearly defined to allow for a clear demarcation between the possible groups involved"*. However, in review, we noted that the *"Table 4-1: Overview of external expert and stakeholder involvement in EUnetHTA 21 productions"* refers to patients only. To avoid any risk of exclusion - real or perceived - we propose that the aforementioned be reformulated and/or replaced by language that speaks to *"patients", "patient representatives" and "patient organisations."* Otherwise, inconsistencies may adversely affect patient interpretation, involvement and/or representation.	Yes	Thank you for your comment. The table has been revised.

Natacha Bolanos, Lymphoma Coalition	17	418	**<u>Composition definition</u>** In the model employed by the European Medicines Agency Patients' and Consumers' Working Party, the composition (or the exact number of members appointed) are clearly defined in the respective mandate, objectives and composition. (1) However, as we reviewed the content found in *Table 5-1: Template to report on patient and healthcare professional involvement* (and specific to patient and healthcare professional involvement) there is a lack of clarity regarding a minimum number of patients and/or clinical experts to be involved. As we view the definition of a minimum number of participants as paramount to transparent and robust health technology processes, and to ensure representation is sufficient to support optimal operations and robust participation and for full transparency, we state our anticipation that a minimum number of individuals be defined in the composition. Additionally, we anticipate that any additional information, protocols, and/or relevant processes specific to the aforementioned will also be clearly defined as/if/where applicable.		Since we are aiming to involve experts with collective knowledge, that can represent a community broader than their member state, therefore, we do not further specify a number of experts to be involved.
Natacha Bolanos, Lymphoma Coalition	20	447-449	**<u>National level disparities: patient involvement</u>** It is our view that the following phrase implies all countries have implemented and/or established protocols, procedures and/or proccesses to guide interaction with patients: "*For interaction with patients and/or clinical expert on a national level, for example when HTAb are defining their PICO, the HTAb are responsible for the communication and ensuring transparency of the input received.*" We believe this is assumptive, taking for granted that there are established and operationalised HTAb structures in place to ensure consistent national involvement of patients across the different countries. We propose reconsidering and/or revisiting this phrase to acknowledge that patient expert involvement practices in		Thank you for your comment. This section has been modified. We acknowledge that indeed not all countries have implemented national procedures for involvement with patients. We also point out that national level involvement is outside of the scope of the HTAR and therefore will not be full addressed in this document.

			some countries may be under development and/or in the infancy stages of integration. Further, when providing examples we suggest consideration be given to the example as disparities at national level persist. We understand that examples may be helpful however, they may not be universally applicable and/or relatable to all countries.		
Natacha Bolanos, Lymphoma Coalition Marjorie Morrison, Lymphoma Coalition		63	**EUnetHTA 21 –Stakeholder Patient Input Template for Joint Clinical Assessments (JCA)** **<u>Funding transparency</u>** We acknowledge that patient organisations are likely to be in receipt of industry funding and therefore accustomed to the corresponding compliance requirements and mandatory reporting to disclose funding sources with full transparency. With respect to, for example, rare diseases in health technology, patient organisations may receive funding from a primary entity and/or from limited sources rather than having access to dispersed funding over multiple streams/sources. Where interpretation of restrictions may further limit inclusion of patient populations less likely to be involved or represented in health technology, a focus on compliance and transparency in reporting of industry funding may help to reduce the risk of any perceived restrictions such as required reporting on the percentage of funding per entity. We therefore propose that the template and relevant guiding documentation provide patient organisations with succinct information and/or clarity with respect to funding reporting expectations to: (a) ensure there is clear and consistent interpretation of information and reporting requirements (b) aim to promote greater inclusion of patient organisations who may not participate due to the aforementioned (c) address the reality that some patient organisations may not be in receipt of multiple		Thank you for your comment. The information on the relevant manufacturers is of importance. This is needed for transparency.

			industry funding sources (d) ensure patient insights meet the expectations and requirements of involvement.		
Roche	1	7-20	There should be a reference to GDPR in the introduction, i.e. how personal data is treated (privacy, security aspects) where relevant.		The patient organisation/stakeholder template does not include any personal or confidential information. No contact details will be released. We will make sure that this is clear in the template.
Roche	1	20	It should be added: ''*Confidentiality agreement should be signed*''		The patient organisation/stakeholder input template is only for JCA (not JSC). We do not ask for any confidential information in the template, therefore no confidentiality agreement is needed. Furthermore, we do not release any contact details of the person that completed the template. We will make sure that this is clear in the template.
Roche	2	52	Suggest to add a tick box for ''*Sign Confidentiality Agreement*''		No confidentiality agreement is needed since no confidential information will be shared. See also answer above.

Roche	2	53-54	It is not clear if the statements will be published anonymous or not or by naming the profession, institution, country or any information. This should be clarified.		In the guidance we say that "Patients speaking on behalf of a patient organisation should be included by their organisation/affiliation and country." Now it says (we add the part in bold):" By submitting this template, I understand and agree that (parts of) my responses can be stated in the JCA report with the organisation/affiliation and country being mentioned. The JCA report will be publicly available on the EUnetHTA21 website."

Comment from	Page number	Line/ section number	Comment and suggestion for rewording **D7.3 Template for patient and clinical expert input** **Individual patient expert input template.**	Editorial comment?	HOG answer
European Patients' Forum	1	9	To add: This template is intended to enable individual patients/patient representatives to present" …	x	Thank you, the text reflects your comment
European Patients' Forum	3	67	Please substitute "health condition(s)" with "chronic disease(s)". Also, add the possibility for cross-disease umbrella organisations to respond.	x	The text has been clarified so that also more generic patient organisations can respond, however, we have not change the wording to 'chronic diseases'
Matias Olsen, EUCOPE	General		There should be more than one version of this template and the existing content should be split into different templates that can be utilised at different times throughout the procedure. This could be done in the following way: An early input template, which could consist of a description of the conditions. Then, a later template could be used when additional information on the treatment/effects can be provided, to gather experiences on the treatment and the interpretation on the extent to which the new treatment addresses unmet needs.		EUnetHTA21 considers the input of stakeholders via the input template most relevant at the beginning of the scoping phase. Thereafter patients might be included via different methods. See our guidance document.
Matias Olsen, EUCOPE	1	15-16	Further transparency on how Assessors can modify the questions is needed. We suggest that the current template forms the base for questions, and specific disease/treatment questions could be added as additional questions.		We agree. The sentence now reads: "All questions can be modified by EUnetHTA (Co-)-Assessors as necessary". It will be modified to "The template forms the basis for questions. If needed, questions can be modified and/or/added by EUnetHTA (Co-)-Assessors."

Matias Olsen, EUCOPE	5	88-89	The impact should be considered also from a carer perspective Add: "For those *with* experience using <name of new therapy/health technology> what impact **or difference** does/did it make to your life (their lives) **or family/carers lives**?"		The current patient input template focuses on the perspective of the patient. We added a recommendation to the guidance that a separate input form for carers might be established.
Matias Olsen, EUCOPE	5	91-94	Phrasing this section as 'expectations from a new treatment' for people that do not yet have experience with it could be confusing. The aim of this section appears to be to elicit perspectives on the unmet needs of patients currently, and we would therefore suggest to reword the section to reflect this. We would also suggest to move this section prior to the 'experience of the treatment' section so that the flow is: Current experience > Unmet Needs > Experience of the treatment in addressing those unmet needs. It is important to ensure that elicitation of this perspective does not get interpretated as judgements on the extent of clinical benefit.		We used the terminology "expectations" from the HTAi patient input template and assume that patients did understand it. We might reword it after using it. Fine with switching the sections around.
Matias Olsen, EUCOPE	7	96-98	Patients and caregivers should have the opportunity to provide feedback on clinical trials, without necessarily being required to do so. While patients can provide important perspectives on general aspects of study design, e.g. the endpoints and Patient Reported Outcomes, it might not be appropriate to ask all patients or caregivers for their perspectives on detailed aspects of the clinical trial design, as all patients might not have the scientific background to adequately comment. Gathering patient perspectives on outcomes of importance to them and whether tools are appropriate could also be conducted as part of instrument validation and reported by the HTD.		We agree. The questions are not mandatory to be filled in anyways - see page 1 line 45-46 where it says "the template compiles possible aspects/options in the response, all of the points listed are optional to be asked/answered."
Marjorie Morrison, Lymphoma Coalition	General		**EUnetHTA 21 – Individual Patient Expert Input Template for Joint Clinical Assessments (JCA) and Joint Scientific Consultations (JSC)**		Thank you for pointing this out. Patients will have the opportunity to mention aspects regarding social determinants in

			<u>Social determinants of health</u> Social determinants of health are broadly defined as the economic and social conditions that shape the health of individuals. It is our experience that the social determinants of health are highly likely to play an influential or impactful role in relation to the daily management of a disease and/or condition. We propose that consideration be given to the indication of the social determinants of health as/where they present as challenges, barriers and/or burden for both patient and carer in the template.		their answers, if considered important to them.
Marjorie Morrison, Lymphoma Coalition	3	69	**EUnetHTA 21 – Individual Patient Expert Input Template for Joint Clinical Assessments (JCA) and Joint Scientific Consultations (JSC)** **<u>Real-world evidence/real-world data</u>** The language of "real-world evidence or real-world data" is not reflected in the document despite the increasing application of both terms in the drug development and global health technology assessment processes and models. We propose consideration be afforded to the integration of terminology in patient-centric templates that acknowledges the language of real-world evidence/real-world data, accompanied by the appropriate level of context and/or clarification as/if/where there is benefit.		Thank you for this comment. We were not able to implement the change, since this might not be applicable. Real world data can be provided by the HTD.
OIFE			General comment to the template: OIFE believes that the focus of the patient input should be on the collective knowledge and that representatives who are able to cover this aspects are preferred. The template accommodates for this in questions 6 and 8 using the words "your (a patiens'), "you (patients)". We suggest that the words change order so that the individual aspect comes last: "a patient's (your)" and "patients (you)".		Thank you, you are right that we aim for collective knowledge. However, we think that it reads better as it is now.

OIFE	3	Question 4	General comment: We acknowledge that individual experiences are appropriate in some instances. In these cases one should be mindful of what (if any) personal/individual health information needs to be included in the minutes. There is a difference relaying this information verbally in a patient interview and having it written down in minutes to be distributed to all the HTA bodies involved. Especially for rare disease patients, knowing just nationality and gender/age, the information may be recognizable. When participating in procedures like this the patient/patient expert is well aware of this, but we ask ourselves if personal health information is necessary to record in minutes for distribution. As stated above we believe that the collective shared experience of the patient group should be preferred and that health related/sensitive information from individuals, should be shared with caution.		Thank you for highlighting this. We will only provide a general description about the patient (without stating the name), which he/she can double check before publication. We are aware that elements could lead to identification of a person, we will evaluate this on a case by case basis, what information is needed to be stated and ask the patient before publication.
OIFE	3	Question 4	It needs to be clarified for the patient what this sentence actually means: “Only the respective EUnetHTA 21 Secretariat and the HTA bodies involved in the procedure will have access to this information.” Since question 4 asks for personal health information we believe it is important to be clarify this more. Even though patients at this level of patient participation are more than willing to share their experiences, one may not want personal health information in minutes that are distributed across Europe. Referring to the comments above, one should strive to collect the collective knowledge rather than the individual perspective.		Indeed we aim to involve patients with collective knowledge. We amended the sentence to "….and/or the disease/condition of the patient(s) you represent." We will only provide a general description about the patient (without stating the name), which he/she can double check before publication. We are aware that elements could lead to identification of a person, we will evaluate this on a case by case basis, what information is needed to be stated and ask the patient before publication.
Roche	2	51	We suggest to add ‘’and JCA’’ as not all JCA information will be published and the Patient Experts could have access to confidential information such as primary indication statement (potentially changed by EMA as a second step) or other informations that won’t		As mentioned in the guidance, patient experts need to sign a DOI and ECA. This is also

			be published (please refer to Roche's consultation comments on D5.1 JCA/CA Submission Dossier Template)		mentioned on page 1 line 18-20.
Roche	2	54-56	It is not clear if the statements will be published anonymous or not or by naming the profession, institution, country or any information. This should be clarified.		In the guidance we say that "Patients involved as external experts are by default not named individually, but a description is provided (including country). Now it says (we add the part in bold):" By submitting this template, I understand and agree that (parts of) my responses can be stated in the JCA report/JSC final recommendations with a general description of myself being mentioned (including country). The JCA report will be publicly available on the EUnetHTA21 website."
Roche	2	60	We suggest that instead of singling out manufacturers as the only conflict, either to mandate a financial breakdown from all major sources or leave it at an open text to declare any and all potential conflicts.		Thank you for your comment. The information on the relevant manufacturers is of importance. This is needed for transparency.
Roche	7	97	On top of ''Issues to consider in your response'' that seems biaised, we suggest to add ''expectations on the drug under development'' like we have for the JCA questionnaire.		Q9 covers this issue - which is also applicable to JSC: "Expectations for the new therapy/health technology being assessed - For those without experience using <name of new therapy/health technology>, what are the expectations for new therapies/health

					technologies in general?" So no addition is needed.
Roche	8	100	The suggestion is to remove ''EUnetHTA'' as those questionnaires are expected to be used beyond EUnetHTA21, under the HTA-R		Thanks. The EUnetHTA21 deliverables might need to be adapted anyways based on the experiences made under EUnetHTA21 (and in order to fully comply with the HTAR and the implementing acts).
Roche	1, 3	7-20, 68	There should be a reference to GDPR already in the introduction, i.e. how personal data is treated (privacy, security aspects) where relevant, as referenced in line 68 For page 3, line 68, previous comments re consent to secondary use of data and/or handover from secretariat to formal HTA body managing the database at a later time, would be great to be included already		The paragraph about GDPR is especially relevant for Question 4, therefore we think it is sufficient to mention it there.
Roche	7	97	PROs: a suggestion would be to also add disease-specific questionnaires/methods; it is not only about how easy they are to complete but also how relevant they are (this comment is based on a recent Resp Patient Council discussion where we changed a PRO subsequent to Patient community insights and other related discussions where relevance is a key topic)		Thanks, the bullet point was amended accordingly. .
IPPOSI	**general**		The template provides a thorough introduction and overview, and the questions include detailed prompts. This can be very helpful to users, but it may be worthwhile to consider the tradeoff between detailed prompts and user-friendliness.		Thank you for your comment. We have clarified that not all prompts have to be answered.
IPPOSI	**general**		It would be helpful to provide a clear statement on the template regarding the confidentiality of information collected.		The patient organisation/stakeholder input template is only for JCA (not JSC). We do not ask for any confidential information in the

					template, therefore no confidentiality agreement is needed. Furthermore, we do not release any contact details of the person that completed the template. We will make sure that this is clear in the template.
IPPOSI	**1**	**25-37**	In this section it states that individuals may add issues that are not covered in the prompts. Given the extent of the texts in the prompts, it may be worthwhile to add this information in other sections of the document as well.		Thank you, we have decided to not add it
IPPOSI	**4**	**72**	It is notable that the term "quality of life" is not used in this section. This may be worth adding to the prompts.		Thank you, this was addressed
IPPOSI	**8**	**103**	Informing individuals how all the information collected from the template will be used would be beneficial. In particular, the inclusion of this 'summary section' without additional information may raise concerns that only this section will be used or will be of primary interest?		Thanks this will be clarified in the template.

Comment from	Page number	Line/ section number	Comment and suggestion for rewording **D7.3 Template for patient and clinical expert input** Clinical expert input template	Editorial comment?	HOG answer
S. Walleser Autiero, Medtronic	3	79	Information on ethnicity might not be able to be collected everywhere, eg it cannot be collected in France.		Correct. Thank you for pointing this out.
Roche	1	31-33	The interviews should be recorded as only a summary of the (Co)-Assessor is not transparent enough, we suggest to provide the full comments from the External Experts (same for Stakeholders).		It is intended that stakeholders will submit a written statement in order to reflect the position of members of the stakeholder organisation. If experts are interviewed we consider that a validated summary of the interview rather than a lengthy transcript is the most efficient way to present the input. This ensures the key points of the discussion are not lost in the text. In the interests of transparency, experts will have the opportunity to review the summary and will be invited to make any additions or amendments if they see fit.
Roche	1	31-33	Why is an interview only possible for clinical experts and not for patient experts or stakeholders (patient and clinical)?		Interviews are possible for both patient and clinical experts. We do not plan to interview stakeholders as a written statement gives stakeholder organisations the opportunity to consult their members and provide a consolidated statement.

Roche	2	69-74	It is not clear if the statements will be published anonymous or not or by naming the profession, institution, country or any information. This should be clarified.		This is outlined in the D7.2 guidance but will also be clarified in the clinical expert template
Roche	2	75-76	Suggest to add ''*and JCA elements that remain confidential and won't be published*"		In the case of a JCA, we do not envisage that any of the questions in the clinical expert template will relate to elements that are confidential in nature
Roche	4-5	79	The form is missing an opportunity to obtain greater context from clinical experts to inform PICO development. We should be obtaining information into the current unmet needs and current treatment goals. This points to the limitations with current treatments from clinical experts. When we consider the intervention, we should understand the clinical experts' perspective on where it would/could fit into the current treatment paradigm. While it is asked what outcomes 'should be assessed', we are missing the opportunity to understand what is measured in clinic and what and how we should measure/interpret treatment response.		Thank you for your comment. We will revisit the questions in the template in light of the topics you have raised. (Co)-Assessors also have the option to modify questions in the template on a case by case basis.

Comment from	Page number	Line/ section number	Comment and suggestion for rewording **D7.3 Template for patient and clinical expert input** Healthcare professional stakeholder input template	Editorial comment?	HOG answer
Mihai Rotaru - EFPIA		Template	EFPIA notices a potential disconnect between the supposed information disclosed along the JCA process and the questions included in the HCP Stakeholder Input Template. According to the Guidance, in the JCA process stakeholders are supposed to be informed of the claimed indication only, while all the other information in the dossier remain confidential until the JCA report is published. However, the HCP Stakeholder Input Template asks to comment about pivotal trials they might be aware of, as well as about differences in population between the clinical trial and the population targeted by the intervention. Moreover, it is also asked whether patients are diagnosed or treated differently in the clinical trial, compared to usual clinical care.		Thank you for your comment. In some cases details of pivotal clinical studies may be published in advance of the JCA. we have clarified in the template that HCPs should only answer these questions if they are aware of such studies.
Marjorie Morrison, Lymphoma Coalition	1	31-33	**EUnetHTA 21 – Stakeholder Patient Input Template for Joint Clinical Assessments (JCA)** **<u>Lymphoma subtypes</u>** The World Health Organization (WHO) Classification of Haematolymphoid Tumours: Lymphoid Neoplasms 2022 edition lists more than 80 types of lymphoma. As highlighted in the 2022 “Lymphoma Care in Europe Report”, it is essential to understand the prevalence, outcomes and/or unmet needs of patients by implementing strategies to encourage the tracking of lymphoma subtypes, data collection standards and guidelines. (4) We greatly value inclusion of the special needs/issues in relation to disease sub-types and wish to reiterate the challenges presented by insufficient data and/or inconsistent reporting of		Thanks for pointing this out.

			disease subtypes, and the interconnected implications and impact to the patient community in relation to data, analysis and inclusion of patient experiences in health technology.		
Dr Daniel Widmer UEMO	6	71	You can add a last question about suggestions fort the choice of relevant experts.	x	Sorry, we are unable to provide a response as we are not sure what you mean by this comment.
Roche	2	58	As suggested above, a prior confidentiality agreement has to be signed also by Stakeholders		Confidential information will not be shared with stakeholders so no confidentiality agreement is required
Roche	2	59-60	It is not clear if the statements will be published anonymous or not or by naming the profession, institution, country or any information. This should be clarified.		This is outlined in the D7.2 guidance but will also be clarified in the HCP stakeholder template
Roche	4-5	70	The form is missing an opportunity to obtain greater context from clinical experts to inform PICO development. We should be obtaining information into the current unmet needs and current treatment goals. This points to the limitations with current treatments from clinical experts. When we consider the intervention, we should understand the clinical experts' perspective on where it would/could fit into the current treatment paradigm. While it is asked what outcomes 'should be assessed', we are missing the opportunity to understand what is measured in clinic and what and how we should measure/interpret treatment response.		Thank you for your comment. We will revisit the questions in the template in light of the topics you have raised. (Co)-Assessors also have the option to modify questions in the template on a case by case basis.