NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Appraisal consultation document

Selpercatinib for RET fusion-positive advanced non-small-cell lung cancer

The Department of Health and Social Care has asked the National Institute for Health and Care Excellence (NICE) to produce guidance on using selpercatinib in the NHS in England. The appraisal committee has considered the evidence submitted by the company and the views of non-company consultees and commentators, clinical experts and patient experts.

This document has been prepared for consultation with the consultees. It summarises the evidence and views that have been considered, and sets out the recommendations made by the committee. NICE invites comments from the consultees and commentators for this appraisal and the public. This document should be read along with the evidence (see the committee papers).

The appraisal committee is interested in receiving comments on the following:

- Has all of the relevant evidence been taken into account?
- Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?
- Are the recommendations sound and a suitable basis for guidance to the NHS?
- Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

Issue date: July 2021

Note that this document is not NICE's final guidance on this technology. The recommendations in section 1 may change after consultation.

After consultation:

- The appraisal committee will meet again to consider the evidence, this appraisal consultation document and comments from the consultees.
- At that meeting, the committee will also consider comments made by people who are not consultees.
- After considering these comments, the committee will prepare the final appraisal document.
- Subject to any appeal by consultees, the final appraisal document may be used as the basis for NICE's guidance on using selpercatinib in the NHS in England.

For further details, see NICE's guide to the processes of technology appraisal.

The key dates for this appraisal are:

Closing date for comments: 27 August 2021

Second appraisal committee meeting: 15 September 2021

Details of membership of the appraisal committee are given in section 5

1 Recommendations

1.1 Selpercatinib is not recommended, within its marketing authorisation, for treating RET fusion-positive advanced non-small-cell lung cancer (NSCLC) in adults who need systemic therapy after immunotherapy or platinum-based chemotherapy.

1.2 This recommendation is not intended to affect treatment with selpercatinib that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

Why the committee made these recommendations

People with RET fusion-positive advanced NSCLC are usually offered docetaxel alone or docetaxel with nintedanib if they need systemic therapy after previous treatment.

Clinical trial evidence suggests some benefit for selpercatinib, but this is highly uncertain because it has not been compared with another treatment. Also, the trial has not been running long enough. Selpercatinib has been compared indirectly with other treatments but the results from this are also highly uncertain.

Cost-effectiveness estimates for selpercatinib compared with other treatments are not robust, and are much higher than what NICE normally considers an acceptable use of NHS resources. Selpercatinib does not meet NICE's end of life or Cancer Drugs Fund criteria because of the lack of robust cost-effectiveness estimates. Therefore, selpercatinib cannot be recommended as a cost-effective use of NHS resources.

2 Information about selpercatinib

Marketing authorisation indication

2.1 Selpercatinib (Retsevmo, Elli Lily) is indicated for the treatment of adults with advanced RET fusion-positive non-small cell lung cancer (NSCLC) who require systemic therapy following prior treatment with immunotherapy and/or platinum-based chemotherapy'.

Dosage in the marketing authorisation

2.2 The dosage schedule is available in the summary of product characteristics.

Price

2.3 The list price for 60 capsules of selpercatinib (80 mg) is £4,680 (excluding VAT; BNF online, accessed July 2021). The company's estimated cost for a 28-day cycle of selpercatinib is £8,736.00.

2.4 The company has a commercial arrangement, which would have applied if the technology had been recommended.

3 Committee discussion

The appraisal committee considered evidence submitted by Eli Lilly, a review of this submission by the evidence review group (ERG), and responses from stakeholders. See the committee papers for full details of the evidence.

The appraisal committee was aware that 1 issue was resolved during the technical engagement stage, and agreed that including genetic testing costs in the model was appropriate.

It discussed issues 1 to 13 identified in the ERG report. It also discussed the possibility of commissioning selpercatinib through the Cancer Drugs Fund.

New targeted treatment

People with RET fusion-positive advanced non-small-cell lung cancer (NSCLC) would welcome a new treatment

3.1 The patient and clinical experts explained that the symptoms of advanced NSCLC (including breathlessness, cough, and weight loss) are hard to treat. Typical treatments for RET fusion-positive advanced NSCLC in the NHS are chemotherapy (such as platinum doublet chemotherapy) and immunotherapy (such as pembrolizumab). The clinical expert and the Cancer Drugs Fund clinical lead from NHS England explained that, for RET fusion-positive NSCLC, docetaxel is the main treatment. But they also explained that some people may also be offered nintedanib with docetaxel, and that these are the only standard treatments for this indication. They explained that use of docetaxel with nintedanib is decreasing because of its limited benefit and increased side effects compared to docetaxel alone. This leaves few options for people with RET fusion-positive advanced NSCLC. Selpercatinib is the first treatment targeted at RET fusion-positive advanced NSCLC and has shown high response rates in some people with this tumour type. The committee concluded that people with RET fusion-positive NSCLC would welcome the introduction of selpercatinib as a treatment option.

Comparators

The relevant comparators are docetaxel alone and docetaxel with nintedanib

3.2 In its original submission, the company provided evidence for a range of comparators based on the NICE scope for this appraisal. Through clinical advice and discussion at technical engagement, the company refined the list of comparators down to docetaxel alone and docetaxel with nintedanib. The ERG suggested that pemetrexed with carboplatin, and platinum doublet chemotherapy remained relevant comparators. The

committee discussed atezolizumab as well. The company explained that advice to both itself and ERG had been clear that people would most likely have immunotherapies first. The company said it was advised that people who have immunotherapies first are not then offered them second line, meaning this class of therapy is irrelevant for this indication. The company said it was also advised that pemetrexed with carboplatin and platinum doublet chemotherapy are rarely used second line. The committee concluded that docetaxel and docetaxel with nintedanib were the appropriate comparators for people with RET fusion-positive NSCLC.

Clinical evidence

The direct clinical evidence for selpercatinib is uncertain because it depends on 1 single-arm study

3.3 The evidence for selpercatinib comes from the LIBRETTO-001 clinical trial. This is a single-arm, open-label, multicentre phase 1 to 2 trial including people with advanced solid tumours with RET activations. The primary outcome of the trial was objective response rate. Secondary outcomes included progression-free survival (PFS), overall survival (OS) and health-related quality of life. A total of 329 people with RET fusion-positive advanced NSCLC were enrolled, and:

- data from 253 people was used in the analyses
- 184 people were enrolled with second-line advanced NSCLC that had been treated with platinum chemotherapy (known as the integrated analysis set [IAS])
- data from 105 people was used in the first data cut (described as the primary analysis set [PAS]).

In the primary analysis set, the objective response rate was 63.8% and the median PFS was 16.53 months. Other trial results were confidential, but the company reported evidence that showed similar results for the PAS and IAS groups. The ERG stated that the data from LIBRETTO-001

was immature because of low numbers of recorded events and short reported follow up. Also, some PFS and OS data was not evaluable. The company was able to provide additional evidence from a later data cut. This provided about 3 more months of data, the results from which were consistent with the results from the IAS. However, the ERG considered that this did not overcome the uncertainty because the data was still immature. The ERG also noted that the company had not included this additional data in its cost-effectiveness modelling using its original data set. The committee agreed that basing the evidence on 1 single-arm study, meant that there was uncertainty in the data for selpercatinib, particularly because the data was immature.

The trial population is generalisable to the NHS population

3.4 The trial population included people who had had platinum chemotherapy, some people who had also had immunotherapy, and some people who had also had a multikinase inhibitor (MKI) such as cabozantinib. The ERG said it would have been more appropriate to provide data for people who had only had chemotherapy and people who had only had immunotherapy. The ERG also said people were unlikely to be offered MKIs in the NHS as part of treatment for RET fusion-positive NSCLC because they do not have a UK marketing authorisation for this indication specifically and are therefore not included in the NICE Pathway on lung cancer. The clinical expert said the trial population did reflect the NHS population for this indication. The company provided data to show the trial groups with and without MKI had similar responses. The ERG acknowledged that the data for the IAS MKI-naive group was similar to the data for the IAS overall. The committee accepted that the LIBRETTO-001 trial population was generalisable to the NHS population of people with RET fusion-positive advanced NSCLC.

Recommendations in this technology appraisal should apply to people with squamous and non-squamous advanced NSCLC

3.5 The marketing authorisation for selpercatinib did not differentiate between people with squamous and non-squamous advanced NSCLC. However, because of the rarity of RET gene fusions in squamous NSCLC, clinical advice, and the very small number of people with squamous NSCLC in the LIBRETTO-001 trial, the company did not present any evidence on using selpercatinib to treat these tumours. The clinical expert said they might expect some difference in the effectiveness of selpercatinib in treating squamous advanced NSCLC. This is because people with squamous NSCLC may be older, have a higher chance of being smokers, and be less fit. However, they expected there would still be some level of response. The Cancer Drugs Fund clinical lead said that the NHS would expect to follow the same recommendation for people with squamous advanced NSCLC as for people with non-squamous advanced NSCLC. The committee agreed that the recommendations in this technology appraisal would apply to both squamous and non-squamous advanced NSCLC.

Indirect treatment comparison

The populations included in the trials used in the network meta-analyses (NMAs) are relevant for the indirect treatment comparisons (ITC)

3.6 Because LIBRETTO-001 was a single-arm trial, ITC was needed to establish the relative efficacy of selpercatinib. The ERG stated that trials used for the ITC were unlikely to have contained substantial numbers of people with RET fusion-positive advanced NSCLC. This was because the mutation is rare (1% to 2% of people with NSCLC). Also, testing was not done for RET fusion status in these trials, which the company acknowledged as a limitation of the data. The company did its ITC by NMA. This method allows for the relative effects estimated in different studies to be pooled if studies are sufficiently similar. To overcome the

limitations noted by the ERG, and to ensure the selected trials were comparable, a control arm for LIBRETTO-001 was needed. The company simulated a control arm (that is, docetaxel with placebo), referred to as the pseudo-control arm, by extracting data from the REVEL NSCLC randomised controlled trial. The aim was to allow for the LIBRETTO-001 data to be compared with the other trials in the ITC. The committee noted that the other trial data was not adjusted for RET status. The clinical expert said that the effect of RET fusion on treatment effectiveness for people with advanced NSCLC is unknown. However, they thought it may become clear over time as more testing is carried out for this form of lung cancer. The committee accepted that, in absence of a direct comparator population with RET fusion-positive NSCLC, the NMA trial populations were relevant for the ITC.

The generation and use of the simulated control arm in NMAs is not robust

3.7 The Flatiron clinic-genomic database was used to provide a range of prognostic factors (such as RET fusion status, age, smoking history and cancer histology). This was to adjust the control arm extracted from the REVEL randomised controlled trial to match the LIBRETTO-001 population. The company said this process had simulated a relevant control arm for LIBRETTO-001, simulating the effect of treating RET fusion-positive advanced NSCLC with docetaxel with placebo. The ERG said the methods used by the company needed multiple statistical steps, and each step created some uncertainty. The company changed its approach after technical engagement, and the ERG pointed out that several issues either remained or had been created by using the new propensity score-matching approach. It also pointed out that the additional data obtained by the company had not been used in the NMAs, which would have ensured as much data as possible was informing the ITC. The ERG emphasised its belief that too much uncertainty remained in the NMAs to make conclusions on the relative efficacy of selpercatinib and

the comparators. The committee agreed that simulating the control using the company's approach did generate uncertainty for the relative efficacy of selpercatinib. It agreed that, in principle, using a simulated control was acceptable. The committee considered that there was not enough evidence to understand the effect of RET fusion status on survival. So, it thought that the relative clinical-effectiveness estimates may have lacked validity. It considered that using hazard ratios not corrected for RET fusion status in the NMA added further uncertainty when determining the relative efficacy of selpercatinib. The committee also considered other forms of NSCLC in the absence of robust data on the effect of RET fusion status, agreeing that the NMA results were not probable. Taking into account section 3.6, the committee concluded that selpercatinib may improve overall response rate, PFS and OS. However, they concluded that the size of the benefit relative to docetaxel monotherapy or docetaxel with nintedanib was uncertain.

The company's economic model

The company's model is appropriate for decision making

3.8 The company used a partitioned-survival economic model that included 3 health states: progression-free, progressed and death. The committee concluded that the model was generally appropriate and consistent with the models used in other appraisals for NSCLC, including:

- NICE's technology appraisal guidance on atezolizumab for treating locally advanced or metastatic non-small-cell lung cancer after chemotherapy
- NICE's technology appraisal guidance on osimertinib for untreated EGFR mutation-positive non-small-cell lung cancer
- NICE's technology appraisal guidance on nivolumab for advanced non-squamous non-small-cell lung cancer after chemotherapy.

The committee concluded that the company's economic model was suitable for decision making.

The modelled results of OS and PFS are not robust

3.9 Having obtained data from LIBRETTO-001 and the simulated control arm, the company used its cost effectiveness model to fit extrapolations for OS and PFS. These were ranked using statistical methods, and also considered by clinical advisers to the company. The company based its conclusions for the selpercatinib arm on the Spline/Knot1 OS extrapolation. This was because its clinical advisers believed this extrapolation fitted most closely to their expectation of clinical reality. The committee noted that clinical expert opinions drew little on experience of the rare RET fusion-positive form of NSCLC. It also noted that there is little long-term experience of using selpercatinib in the NHS. The ERG said that selection based on clinical advice, rather than selection based on statistical tests, was open to bias. The direction and magnitude of any bias was not deducible from the data. The ERG did not select a preferred alternative base-case extrapolation because it thought the data and NMAs were too uncertain to make this possible. It noted that the Gompertz alternative extrapolation would match the clinical evidence most closely and would be just as appropriate a selection of extrapolation as Spline/Knot1. However, it noted that it resulted in substantially different cost-effectiveness results. A different approach was used for selpercatinib PFS, in that the stratified Gompertz distribution was used to fit the data. This was fixed in the company's modelling when it went on to model OS. The committee discussed the divergence of the different extrapolations presented, and that this was in part caused by the short follow up of the LIBRETTO-001 trial. The ERG said that, based on its inspection of extrapolations fit to the LIBRETTO-001 data, OS for selpercatinib appeared to have been overestimated by the company. The clinical expert and Cancer Drugs Fund clinical lead supported this view and added that this was also true in the comparator arms. The clinical expert expected

OS to be about 9 to 10 months for docetaxel, rather than the higher values seen in the survival extrapolations presented for discussion. They explained that it was feasible that people with RET fusion-positive advanced NSCLC could have greater OS than people with other forms of advanced NSCLC. This was particularly because they tend to be younger and non-smokers, which might explain some of the higher-than-expected OS in the docetaxel arm. However, they noted that there was no evidence to support this. The company explained that the increase in OS from 9 months in the simulated control arm was because of the adjustment processes for RET fusion status used in its generation. The committee acknowledged the uncertainty in the OS and PFS estimates, and in particular the wide range of extrapolations for selpercatinib. It concluded that the survival estimates for the control arm were implausibly long and that this would mean the conclusions based on the model were not robust.

The economic model should use time to discontinuation (TTD) when calculating the cost of selpercatinib

3.10 The original company model used PFS to calculate the cost of selpercatinib. The ERG said that using TTD would be more accurate, and the company subsequently used what they termed a conservative estimate for TTD in its updated model. The ERG noted that functionality in the model was removed at this stage and preferred to incorporate a parametric extrapolation for TTD into the original model. The company stated that this approach overestimated TTD, and therefore costs, because the data was immature. The clinical expert said that the costs of selpercatinib would be higher if estimated using TTD rather than PFS. This was because it is common practice for people to continue taking a treatment even if their disease progresses. This could be because an initially large tumour is substantially reduced, so progression would still be less severe than their initial disease status. Or it could be because 1 or more secondary tumours have progressed but there is still a positive effect on the primary tumour from taking the treatment. It would be

unlikely patients would still be on the treatment 2 years after progression. The committee concluded that the costs of selpercatinib should be modelled using extrapolated TTD.

The cost of genetic testing for RET fusions should be incorporated into the economic model

3.11 The company did not include costs for genetic testing for RET fusions into its original cost-effectiveness model. This was because it expects such testing to be done routinely within the NHS. The Cancer Drugs Fund clinical lead confirmed that testing for RET fusions is available in the NHS as a fluorescent in-situ hybridisation test. However, access to this test is not routine or part of normal screening at the NHS Genomic Medicine Service. The clinical expert said that next generation sequencing screening panels would be adapted to include testing for RET fusions when possible. However, at the time of this appraisal for selpercatinib this was not considered routine. Therefore, NHS England provided a suitable cost per test to the company, and the company included this in its economic model. The committee agreed this was appropriate.

Utility values in the economic model

The progressed disease utility value used by the company is acceptable in absence of more robust data

3.12 The ERG pointed out an inconsistency in the company's approach to utility values used in the model. In general, the company took its utility values from NICE's technology appraisal guidance on nivolumab for advanced non-squamous non-small-cell lung cancer after chemotherapy. However, it had not used the utility value from this appraisal for progressed disease (PD) of 0.569. The company collected health-related quality of life in the LIBRETTO-001 trial, calculating a PD utility value of 0.688. The ERG was concerned that this was high compared with the value from the nivolumab appraisal. It noted that the company had not

gathered EQ-5D data but had used the European Organisation for Research and Treatment of Cancer (EORTC) QLQ-C30 questionnaire. The company followed a method reported in the literature to map EORTC to EQ-5D. However, the new PD value obtained was higher than the original PD value of 0.688. The company decided to use the midpoint between 0.569 and 0.688 in its model, which was 0.628. The ERG said this decision was relatively arbitrary and maintained its view that the value from the nivolumab appraisal should be appropriate for this population. The clinical expert stated that people with RET fusion-positive advanced NSCLC tend to be younger and have never smoked. So, they thought it was feasible they might have generally higher utility values than people with other forms of lung cancer. The committee decided that the PD value used by the company in the revised model was acceptable for decision making in absence of more robust data.

End of life

The evidence is not sufficiently robust to determine if selpercatinib meets the criteria to be an end of life treatment

3.13 The committee considered the advice about life-extending treatments for people with a short life expectancy in NICE's guide to the methods of technology appraisal. The company's base-case estimate for the median OS for people offered docetaxel was less than 24 months, and it did not provide an estimate of the mean. However, the company explained that it believes this to be an overestimate compared with clinical expert opinion that this is 9 to 10 months. The ERG's estimates for OS for people offered docetaxel with or without nintedanib were higher than those of the company, above 24 months. The company thought the ERG's extrapolations for survival were overestimates. The committee noted the comments from the clinical expert and considered that the expected survival of people with RET fusion-positive advanced NSCLC who were not offered selpercatinib might be much less than 24 months in practice.

However, the committee was aware that all the modelled estimates presented suggested this was close to, or more than, 24 months. This meant that the committee thought the modelled estimates were not sufficiently robust to estimate life expectancy. However, it accepted that life expectancy could be less than 24 months, so concluded the short life expectancy criterion was likely to be met. The company proposed that selpercatinib extended life by more than 3 months compared with standard care. In its base case, the company estimated that selpercatinib would extend life expectancy by much more than 3 months (the company's modelled estimates are confidential and cannot be presented here). The ERG thought that this was feasible according to the data, but highly uncertain because of the difference between clinical expert opinion and company estimates. The committee recalled its concerns about uncertainty present in the OS estimates generated using the model. It concluded that, because of its concerns with the NMA and the lack of robust results from the model, the company's estimate of extending life expectancy was not reliable and so the life extension criterion was not met. Therefore, the committee concluded selpercatinib did not meet the criteria to be considered an end of life treatment, based on the evidence presented and in the absence of a robust estimate of extension of life.

Cost-effectiveness estimates

The range of plausible incremental cost-effectiveness ratios (ICERs) is large because of data immaturity

3.14 The company presented a base-case ICER of £74,833 per quality-adjusted life year (QALY) gained for selpercatinib compared with docetaxel, and £69,411 per QALY gained for selpercatinib compared with docetaxel with nintedanib (not accounting for the confidential discount which applies to nintedanib, which increases the ICER). The ERG made 2 changes to the base case:

- It applied the progressed disease health state value from NICE's technology appraisal guidance on nivolumab for advanced non-squamous non-small-cell lung cancer after chemotherapy.
- It modelled the costs of selpercatinib based on TTD rather than PFS.

The ERG presented alternative base cases. These were £116,393 per QALY gained for selpercatinib compared with docetaxel, and £116,790 per QALY gained for selpercatinib compared with docetaxel with nintedanib (not accounting for the confidential discount that applies to nintedanib, which increases the ICER). It maintained that the data underpinning the cost-effectiveness model was uncertain because of the issues mentioned in sections 3.3, 3.6, 3.7, 3.9, so would not provide an ERG-preferred ICER. The committee acknowledged the large range of plausible ICERs because of data immaturity and modelling assumptions. It also noted that all presented ICERs were outside the range typically considered cost effective for use in the NHS. The committee did not define a preferred ICER because of this uncertainty.

Other factors

Selpercatinib is an innovative product

3.15 The committee noted that, unlike docetaxel, selpercatinib is an oral drug, and it specifically targets RET fusion-positive NSCLC. The committee considered that the model structure should be able to capture the benefits and costs of selpercatinib in terms health-related quality of life, and QALYs gained.

Conclusion

Selpercatinib is not recommended for use in the NHS

3.16 The committee was aware that the evidence base will necessarily be weaker for some rare indications such as RET fusion-positive advanced NSCLC because of the low number of patients. Based on section 6.2.16

of NICE's guide to the methods of technology appraisal, the committee considered that the economic modelling estimates presented were not clinically plausible, so were not robust. The committee recalled that there are no targeted treatments currently available for RET fusion-positive advanced NSCLC, as discussed in section 3.1. It noted the clinical- and cost-effectiveness evidence was highly uncertain because of the immaturity of the data from the LIBRETTO-001 trial. It also noted that the ITC using NMAs based on the simulated control arm were highly uncertain. Selpercatinib did not meet NICE's end of life criteria because of this uncertainty and the lack of robust estimates from the cost-effectiveness modelling. The committee was unable to define a preferred ICER because:

- of the lack of robust evidence
- all presented ICERs were well above the range normally considered a cost-effective use of NHS resources.

Therefore, it could not recommend selpercatinib for routine use for treating RET fusion-positive advanced NSCLC.

Cancer Drugs Fund

Selpercatinib should not be included in the Cancer Drugs Fund

3.17 Having concluded that selpercatinib could not be recommended for routine use, the committee then considered whether it could be recommended for treating RET fusion-positive advanced NSCLC within the Cancer Drugs Fund. The committee discussed the arrangements for the Cancer Drugs Fund agreed by NICE and NHS England in 2016, noting NICE's Cancer Drugs Fund methods guide (addendum):

- The company had expressed that it thought the Cancer Drugs Fund may be appropriate for selpercatinib.

- The key uncertainties were the accuracy and clinical feasibility of the OS and PFS extrapolations.
- Further data collection in the ongoing LIBRETTO-001 trial may reduce the uncertainties in the OS and PFS extrapolations.
- Further data collection in the ongoing LIBRETTO-001 trial would not reduce uncertainty in the comparison of selpercatinib against docetaxel and would not provide direct comparison data.
- All presented ICERs were outside the range normally considered cost effective in the NHS.

The committee noted the lack of robust comparator survival estimates and any presented ICERs within the cost-effective range. It considered that there was not plausible potential for selpercatinib to be considered a cost-effective use of NHS resources through the Cancer Drugs Funds. Therefore, the committee did not recommend selpercatinib for inclusion in the Cancer Drugs Fund.

4 Proposed date for review of guidance

4.1 NICE proposes that the guidance on this technology is considered for review by the guidance executive 3 years after publication of the guidance. NICE welcomes comment on this proposed date. The guidance executive will decide whether the technology should be reviewed based on information gathered by NICE, and in consultation with consultees and commentators.

Peter Jackson
Chair, appraisal committee
July 2021

5 Appraisal committee members and NICE project team

Appraisal committee members

This topic was appraised as a single technology appraisal by the highly specialised technologies evaluation committee. Because of this, some members of the technology appraisal committees were brought in to provide additional expertise to the committee. The 4 technology appraisal committees are standing advisory committees of NICE.

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

The minutes of each appraisal committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

NICE project team

Each technology appraisal is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the appraisal), a technical adviser and a project manager.

Stephen Norton
Technical lead

Christian Griffiths
Technical adviser

Gavin Kenny
Project manager

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