**National Institute for Health and Care Excellence**

**Health Technology Evaluation**

**SQ HDM SLIT for treating allergic rhinitis and allergic asthma caused by house dust mites [ID6280]**

**Response to consultee and commentator comments on the draft remit and draft scope (pre-referral)**

**Please note:** Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees.

**Comment 1: the draft remit**

| Section | Consultee/ Commentator | Comments [sic] | Action |
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| Appropriateness | ALK-Abelló Ltd | Yes [is appropriate] | Comment noted. No action required. |
| Royal College of Physicians (RCP) | Yes [is appropriate] | Comment noted. No action required. |
| Royal College of Pathologists | Yes [is appropriate] | Comment noted. No action required. |
| UK Clinical Pharmacy Association (UKCPA) | Yes [is appropriate] | Comment noted. No action required. |
| British Thoracic Society | Yes [is appropriate] | Comment noted. No action required. |
| Wording | ALK-Abelló Ltd | To appraise the clinical and cost effectiveness of standardised quality house dust mite sublingual immunotherapy (SQ HDM SLIT) within its marketing authorisation for XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | Comment noted. SQ HDM SLIT will be evaluated in line with its marketing authorisation. No action required. |
| Royal College of Physicians (RCP) | Yes [is appropriate] | Comment noted. No action required. |
| UK Clinical Pharmacy Association (UKCPA) | Yes [is appropriate] | Comment noted. No action required. |
| British Thoracic Society | It appears to be [appropriate] | Comment noted. No action required. |
| Timing Issues | ALK-Abelló Ltd | To ensure XXXXXXXXX within the UK are appropriately diagnosed treated with the add on immunotherapy based on the allergic component considering this is already available within other countries for patients to benefit from. | Comment noted. This topic has been scheduled into the work programme. No action required. |
| Royal College of Physicians (RCP) | Standard | Comment noted. This topic has been scheduled into the work programme. No action required. |
| UK Clinical Pharmacy Association (UKCPA) | Important to address as allergy services are keen to start prescribing and supporting this group of patients. NICE guidance will support services to implement.  Currently unlicensed product prescribed by allergy services but now licensed product available in the UK | Comment noted. This topic has been scheduled into the work programme. No action required. |
| British Thoracic Society | Not Urgent | Comment noted. This topic has been scheduled into the work programme. No action required. |

Comment 2: the draft scope

| Section | Consultee/ Commentator | Comments [sic] | Action |
| --- | --- | --- | --- |
| Background information | ALK-Abelló Ltd | XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | Comment noted. NICE will appraise the technology within its marketing authorisation. No action required. |
| Royal College of Physicians (RCP) | It is accurate and complete | Comment noted. No action required. |
| Royal College of Pathologists | - Reference 4 is not a peer reviewed source  - Nasal polyps are usually not a complication of Allergic rhinitis   * Include Leukotriene antagonists ( eg. Montelukast) in the treatment of   Allergic Rhinitis  - Need to recognise “Sensitisation” ( positive test) is common - not all with a positive test have HDM allergy   * Under Allergic Asthma :   Include NICE TA 751 : Dupilumab for treating severe asthma with Type 2 inflammation   * Note in NICE TA278 : Omalizumab was not used in a specific Allergic asthma – it was used in difficult to control asthma with Total IgE as a marker of “ Atopy” Type 2 inflammation * Note currently most Allergy and Immunology services in the NHS use SCIT [ Subcutaneous Immunotherapy] with Alutard SQ HDM injections [ Unlicensed] * Note many NHS Allergy and Immunology services have started using HDM subliqual immunotherapy [ Acarizax ] since the UK marketing authorisation. * The efficacy of SCIT if considered to be better than SLIT – consider including the cost effectiveness of SCIT HDM vs SLIT HDM ? * Consider exploring where SCIT and SLIT for HDM sit it the clinical management of HDM Allergy. | Comment noted. Reference to the British Society for Allergy and Clinical Immunology (BSACI) guidelines is now included in the draft scope. Reference to NICE TAs for relevant biological treatments have been included in the background section of the draft scope. |
| UK Clinical Pharmacy Association (UKCPA) | Correct  • When is the test undertaken in clinical practice?  - GP practices do not routinely undertake specific IgE testing and perform skin prick tests. Referral to secondary care +/- allergy services are required in most areas for these tests to be ordered. Integrated care services are supporting such investigations through reviews with GP practices  • Which test is most commonly used?  Specific IgEs and SPTs | Comment noted. No action required. |
| British Thoracic Society | Suggest include reference to recent European Academy of Allergy and Clinical Immunology guidelines on: Allergen Immunotherapy- house dust mite driven allergic asthma | Comment noted. The background section is intended to give a summary of the condition and current treatment options. The scope references national guidance. No action required. |
| The technology/ intervention | ALK-Abelló Ltd | Standardised Quality house dust mite sublingual immunotherapy (12-SQ HDM SLIT) (Acarizax, ALK-Abelló) contains highly standardised group 1 and group 2 allergens from the 2 house dust mite species Dermaophagoides pteronyssinus and Dermatophagoides farinae. Acarizax is an allergy immunotherapy; repeated administration of high doses of allergens that causes an increase in house dust mite specific immunoglobulin 4 and a systemic antibody response that can reduce the amount of IgE that binds with house dust mite allergens with the purpose of modifying the immunological response to the allergen. It is administered sublingually and given daily for 3 years as per international guidelines. | Comment noted. No action required. Please note that since the scope was issued for consultation NICE no longer reports the mechanism of action of technologies in its scopes. |
| Royal College of Physicians (RCP) | Yes [described appropriately] | Comment noted. No action required. |
| Royal College of Pathologists | Yes [described accurately]  There are other products for house dust mite sublingual immunotherapy which are not licenced – which are being used in NHS services in the management of HDM allergy  Would it be relevant to capture these and then state this HTA is specific for “ Acarizax” as it has UK marketing authorisation.  The other products use same technology intervention | Comment noted. The title of the topic states the intervention. No action required. |
| UK Clinical Pharmacy Association (UKCPA) | Correct | Comment noted. No action required. |
| British Thoracic Society | It appears to be [accurate] | Comment noted. No action required. |
| Population | ALK-Abelló Ltd | * SQ HDM SLIT as an add-on to standard therapy * People aged 18 to 65 years with house dust mite sensitisation with moderate to severe allergic rhinitis despite use of symptom relieving medication and/or allergic asthma not well controlled by inhaled corticosteroids and associated with mild to severe allergic rhinitis. | Comment noted. The draft scope refers to SQ HDM SLIT as an add-on to standard therapy. The technology will be evaluated within its marketing authorisation. |
| Royal College of Physicians (RCP) | Yes [defined appropriately] | Comment noted. No action required. |
| Royal College of Pathologists | Yes [defined appropriately] | Comment noted. No action required. |
| UK Clinical Pharmacy Association (UKCPA) | Yes but would consider the additional text as below:  People aged 18 to 65 years with house dust mite sensitisation with moderate to severe allergic rhinitis despite use of symptom relieving medication and/or allergic asthma not well controlled by inhaled corticosteroids (and a trial of a leukotriene receptor antagonist and optimal dose antihistamine) and associated with mild to severe allergic rhinitis.  Recommend adding in a statement to ensure that adherence to standardised treatment has been assessed and where sub-optimal support provided. This should include nasal spray technique as well as optimum prescribing and patient adherence to the regimen | Comment noted. The technology will be assessed within its marketing authorisation and the population described in the scope reflects this. It is anticipated that the committee will consider the appropriate pathway position for the technology, and how eligibility for treatment would be determined in clinical practice during the appraisal.No action required. |
| British Thoracic Society | 12-17 year group needs to also include presence of asthma | Comment noted. The marketing authorisation does not include this group. No action required. |
| Comparators | ALK-Abelló Ltd | Currently no comparators | Comment noted. At the scoping workshop attendees stated that this technology would likely be used before the use of biologic treatments for allergic asthma. Therefore omalizumab has been removed as a potential comparator |
| Royal College of Physicians (RCP) | Yes [treatments listed are relevant] | Comment noted.. At the scoping workshop attendees stated that this technology would likely be used before the use of biologic treatments for allergic asthma. Therefore omalizumab has been removed as a potential comparator |
| Royal College of Pathologists | In the comparators should only Omalizumab is mentioned for asthma.  A significant proportion of “Atopic Asthma” are eosinophilic – hence the assessment for eligibility for other biological treatments by an expert asthma specialist clinic should precede consideration of HDM SLIT for Asthma.  Suggest include  [NICE Guidance TA565 Benralizumab](https://www.nice.org.uk/guidance/ta565)  [NICE Guidance TA671 Mepolizumab](https://www.nice.org.uk/guidance/TA671)  [NICE Guidance TA278 Omalizumab](https://www.nice.org.uk/guidance/ta278)  [NICE Guidance TA479 Reslizumab](https://www.nice.org.uk/guidance/ta479) | Comment noted. At the scoping workshop, clinical experts stated that this technology would likely be used before the use of biologic treatments for allergic asthma. Therefore omalizumab has been removed as a potential comparator The reference NICE technology appraisals have now been included in the background section of the draft scope. |
| UK Clinical Pharmacy Association (UKCPA) | Yes   * Do treatment options differ for adults compared with adolescents (aged 12 to 17 years)?   No   * What immunotherapies, if any, are currently used? Currently Grazax and Oralvac SLIT. * Is SQ HDM SLIT already used in the NHS?   Yes Oralvac drops but these are unlicensed in the UK.   * Would SQ HDM SLIT be used as an add-on to standard therapy   Yes, certainly initially | Comments noted. At the scoping workshop attendees stated that this technology would likely be used before the use of biologic treatments for allergic asthma. Therefore omalizumab has been removed as a potential comparator. |
| British Thoracic Society | No data on comparing to omalizumab | Comment noted. No action required. |
| Outcomes | ALK-Abelló Ltd | * use of inhaled corticosteroid (ICS)/ ICS LABA (long acting B-agonist) * use of rescue medication * time to first moderate or severe asthma exacerbation after ICS reduction * reduction of the risk of an asthma exacerbation * lung function * adverse effects of treatment * health-related quality of life * overall survival * Asthma control test | Comments noted. The outcomes section is not intended to be an exhaustive list. It is anticipated that asthma control may be captured by the other outcomes. However if there are other measures of asthma control which have not been captured these can be considered during the appraisal. No action required. |
| Royal College of Physicians (RCP) | Yes, However rhinitis does not usually affect overall survival. Effect on work productivity and time off work may also be a useful outcome measure | Commet noted, Overall survival has been removed as an outcome for allergic rhinitis. Effect on productivity and time off work do not form part of the [NICE reference case](https://www.nice.org.uk/process/pmg36/resources/nice-health-technology-evaluations-the-manual-pdf-72286779244741), but may be considered by the committee when as part of the impact of the condition on patients. |
| Royal College of Pathologists | * “Immunological response to treatment” -- one does not measure laboratory immunological parameters ( IgG / IgG4 specific to HDM ) is assessment of response in routine clinical practice. These assays are not routinely available. They have been only been used in research to help understand the mechanism of how immunotherapy works. * There are no standardised parameters with regards what can be considered as a “immunological response” * “Nasal polyps” is not usually considered a complication of Allergic rhinitis * Days lost in school and work can be useful comparator | Comment noted. Immunogloical response to treatment has been removed as a outcome from the draft scope. Reference to nasal polyps has also been removed. Effect on days lost in school and work do not form part of the [NICE reference case](https://www.nice.org.uk/process/pmg36/resources/nice-health-technology-evaluations-the-manual-pdf-72286779244741), but may be considered by the committee when as part of the impact of the condition. |
| UK Clinical Pharmacy Association (UKCPA) | Yes [defined appropriately] | Comment noted. No action required. |
| British Thoracic Society | HDM with allergic rhinitis- should not be a comparison group; presence of asthma should be considered and therefore asthma related outcome measures are relevant.  In addition to ‘use of ICS’ also include dose of ICS (this was captured in the clinical trial).  Suggest do not use ‘overall survival’ | Outcomes listed in the scope are kept broad and are not exhaustive. It is anticipated that dose of ICS could be considered within use of ICS. Overall survival has been removed for allergic rhinitis |
| Equality and Diversity | Royal College of Physicians (RCP) | It does not need changing to meet equality aims | Comment noted. No action required. |
| Royal College of Pathologists | No concerns | Comment noted. No action required. |
| Other considerations | ALK-Abelló Ltd | Current pharmacotherapy options for AA (and AR) are symptom relieving and do not modify the disease course. Although symptom-relieving pharmacotherapy can be effective, a proportion of patients with HDM AA (and associated with HDM AR) remain inadequately controlled, and/or unsatisfied with their treatment | Comment noted. The comparator described in the draft scope includes the current standard of care treatment. No action required. |
| UK Clinical Pharmacy Association (UKCPA) | Adherence to SQ HDM SLIT should be monitored to ensure effectiveness in real life situations | Comments noted. If evidence allows, the committee may consider how adherence impacts clinical effectiveness. No changes required to the scope. |
| Innovation | ALK-Abelló Ltd | This is an innovative technology in terms of being an add on therapy currently placed at step 3+4 as controller options withing GINA guidelines.  Currently there are no treatments specifically targeted at treating the allergic component of the upper airways which has a direct impact on the level of asthma control with both the upper and lower airways being connected. | Comment noted. The committee will consider the appropriate position in the treatment pathway for this treatment based on the evidence provided.  The committee will consider whether SQ HDM SLIT is innovative. No changes to the scope required. |
| Royal College of Physicians (RCP) | The technology is a ‘step-change’ in the management of the condition. Health benefits may not be captured in standard Quality of Life measures used in QALY calculations as allergic rhinitis has a high morbidity, but that morbidity does not affect overall survival or most activities of daily living. Severe Allergic rhinitis has impact on overall psychological health, work performance and time off work and this is poorly captured in standard Quality of Life measures used in QALY calculations. | Commented noted. The committee will consider whether SQ HDM SLIT is innovative. No changes to the scope required |
| Royal College of Pathologists | NHS Allergy and Immunology services are already using HDM SCIT and HDM SLIT – there is significant geographical variation in access to allergen immunotherapy / desensitisation (eg. HDM)  A NICE HTA would enable reduce this variation and current postcode lottery in accessing these treatments.  It will also lead to an increased awareness of allergen immunotherapy in primary care.  Facilitate shared care agreements between Allergy and Immunology centres and Primary care to deliver this management pathway | Commented noted. The committee will consider whether SQ HDM SLIT is innovative. No changes to the scope required. |
| UK Clinical Pharmacy Association (UKCPA) | Unlicensed Oralvac currently being prescribed. Data from current services in terms of outcomes would be valuable to support this appraisal | Commented noted. The committee will consider whether SQ HDM SLIT is innovative. No changes to the scope required |
| British Thoracic Society | The clinical trials for the use of this technology in patients with asthma had moderate results. The use of SLIT is included in GINA and EAACI guidelines and has been recently appraised by EAACI to be cost effective. Based on their calculcations- there is a QALY benefit.  The technology is likely to be used after standard medical management and while it may be included in guidelines it is unlikely to be associated with a significant impact on health related benefits | Commented noted. The committee will consider whether SQ HDM SLIT is innovative. No changes to the scope required. |
| Questions for consultation | Royal College of Physicians (RCP) | **Is a test for house dust mite sensitisation (for example, skin prick test and/or specific IgE) routinely undertaken for all people with house dust mite induced allergic rhinitis and allergic asthma associated with house dust mite rhinitis?** Yes it is   * **When is the test undertaken in clinical practice?** At the initial F2F clinic visit * **Which test is most commonly used?** Skin prick testing if available if not Specific IgE blood test   **Have all relevant comparators for** **SQ HDM SLIT been included in the scope?** Yes   * **Which treatments are considered to be established clinical practice in the NHS for persistent moderate to severe house dust mite induced allergic rhinitis despite use of symptom-relieving medication? In particular:**   + **Do treatment options differ for adults compared with adolescents (aged 12 to 17 years)? The position of SLIT in the treatment ladder for allergic rhinitis is different for adult compared to adolescents. In adolescents the recommendation is that SLIT be considered in patients who have failed antihistamine treatment while in adults it is recommended in patients who have failed on triple therapy of oral antihistamines, intranasal corticosteroids and intranasal antihistamines plus antihistamine eye drops and leukotriene antagonist**   + **What immunotherapies, if any, are currently used? Is** **SQ HDM SLIT already used in the NHS?** House Dust Mite SLIT and SCIT is currently used in the NHS however some formulations being used are on named patient basis   + **Would SQ HDM SLIT be used as an add-on to standard therapy?** Yes it is used as an add-on therapy. * **Which treatments are considered to be established clinical practice in the NHS for house dust mite induced allergic asthma associated with house dust mite rhinitis not well controlled by inhaled corticosteroids?** The next step of treatment above monotherapy with inhaled corticosteroids is combination inhaler of long acting beta-2 agonist inhaler with inhaled corticosteroids   + **Would SQ HDM SLIT be used as an add-on to standard therapy?** There is a potential position for SQ HDM SLIT to be used as an additional step in the asthma treatment ladder prior to the use of biologics * Does treatment of house dust mite induced allergic rhinitis or allergic asthma differ according to severity of symptoms (for example, mild, moderate, severe)? **Yes, there is a treatment** **escalation in patients, starting with either oral antihistamines or intranasal corticosteroids, followed by having both oral antihistamines and intranasal corticosteroids, adding in intranasal antihistamines followed by the addition of oral montelukast. Alongside this patients may also have ocular antihistamines**   + **How is disease severity assessed in these populations?** The mini-RQLQ and RQLQ are useful in determining severity, visual analogue scales are also utilised   Are the outcomes listed appropriate? Yes, However allergic rhinitis does not usually affect overall survival. Effect on work productivity and time off work may also be a useful outcome measure  Are there any subgroups of people in whom SQ HDM SLIT is expected to be more clinically effective and cost effective or other groups that should be examined separately? It is difficult to determine clinically if a patient has allergic rhinitis secondary to HDM allergy or non-allergic rhinitis with sensitization (and not allergy to HDM). If the former patient group could be identified this should improve clinical efficacy at a population level. The patient group of non-allergic rhinitis with sensitization (and not allergy to HDM) are unlikely to respond to SQ HDM SLIT.  Where do you consider SQ HDM SLIT will fit into the existing NICE pathway, [Asthma](https://pathways.nice.org.uk/pathways/asthma)? There is a potential position for SQ HDM SLIT to be used as an additional step in the asthma treatment ladder prior to the use of biologics  NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others.  Please let us know if you think that the proposed remit and scope may need changing in order to meet these aims. In particular, please tell us if the proposed remit and scope:   * could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which SQ HDM SLIT is licensed; * could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology; * could have any adverse impact on people with a particular disability or disabilities.   Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts. The proposed remit and scope does not need changing to meet equality aims  Do you consider SQ HDM SLIT to be innovative in its potential to make a significant and substantial **impact on health-related benefits and how it might improve the way that current need is met (is this a ‘step-change’ in the management of the condition)?** The technology is a ‘step-change’ in the management of the condition.  **Do you consider that the use of SQ HDM SLIT can result in any potential significant and substantial health-related benefits that are unlikely to be included in the QALY calculation?** Health benefits may not be captured in standard Quality of Life measures used in QALY calculations as allergic rhinitis has a high morbidity, but that morbidity does not affect overall survival or most activities of daily living. Severe Allergic rhinitis has impact on overall psychological health, work performance and time off work and this is poorly captured in standard Quality of Life measures used in QALY calculations. | Comments noted. Please see relevant responses in other sections of this document. |
| British Thoracic Society | * The tests are generally not carried out for everyone with a potential diagnosis of allergic rhinitis at present. * Skin prick testing: carried out in secondary and tertiary care and only if clinically indicated or presenting with uncontrolled symptoms * Testing for specific IgE: can be carried out in primary care but only if symptoms uncontrolled despite medical management; carried out in secondary and tertiary care if uncontrolled asthma * Standard treatment: allergen avoidance, nasal corticosteroid spary, nasal douche, nasal corticosteroid/antihistamine combination spray; regular antihistamines * Often the BSACI rhinitis guidelines are used to help determine treatment options.   HDM SLIT not routinely used in adults | Comments noted. Please see relevant responses in other sections of this document. |
| Additional comments on the draft scope | ALK-Abelló Ltd | XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ACARIZAX® is different from STG320 in that ACARIZAX® holds a dual indication for both AR + AA, STG320 is singularly indicated in AR. | Comment noted. No action required. |
| UK Clinical Pharmacy Association (UKCPA) | Where do you consider SQ HDM SLIT will fit into the existing NICE pathway, Asthma?  Currently SLIT does not fit into the current Asthma pathway. Standard practice is to follow British Asthma Guidelines (NICE or BTS/SIGN) to control asthma symptoms with prescribing rhinitis treatments appropriately. Patients with severe disease who present with this phenotype will be prescribed omalizumab as per NICE guidance and licensing. Many allergy patients have very high Total IgEs and therefore fall outside the licensing dosing criteria for omalizumab and are excluded from treatment | Comment noted. The committee will consider the appropriate position in the treatment pathway based on the evidence presented. No action required. |
| British Thoracic Society | The guideline group should acknowledge that asthma with HDM sensitisation and HDM driven allergic asthma are different and clinically it can be challenging to differentiate between them  **Questions for consultation**  Is a test for house dust mite sensitisation (for example, skin prick test and/or specific IgE) routinely undertaken for all people with house dust mite induced allergic rhinitis and allergic asthma associated with house dust mite rhinitis?   * When is the test undertaken in clinical practice?   Skin prick testing: only undertaken in secondary and tertiary care clinics. In secondary care if the patient has uncontrolled asthma. In tertiary care- in the asthma clinic and if clinically indicated in the allergy clinic.  Specific IgE testing: not routinely done in primary care, but in select cases only; in secondary and tertiary clinics- not routinely done in all; select cases only   * Which test is most commonly used?   In primary care blood tests are most commonly used. In secondary care- in general blood tests as skin prick tests are generally only available in specialist clinics in tertiary care  Have all relevant comparators for SQ HDM SLIT been included in the scope?   * Which treatments are considered to be established clinical practice in the NHS for persistent moderate to severe house dust mite induced allergic rhinitis despite use of symptom-relieving medication? In particular:   + Do treatment options differ for adults compared with adolescents (aged 12 to 17 years)?   + What immunotherapies, if any, are currently used? Is SQ HDM SLIT already used in the NHS? Not routinely   + Would SQ HDM SLIT be used as an add-on to standard therapy? If introduced into guidelines- would be used as an add-on to standard therapy, if standard therapy did not control symptoms. * Which treatments are considered to be established clinical practice in the NHS for house dust mite induced allergic asthma associated with house dust mite rhinitis not well controlled by inhaled corticosteroids?   This would depend on the severity of symptoms and confirmed adherence to other treatments. If asthma symptoms are uncontrolled and patients are experiencing >4 exacerbations of asthma requiring oral steroids then treatment with omalizumab is considered   * + Would SQ HDM SLIT be used as an add-on to standard therapy?   Add-on (not replacement)   * Does treatment of house dust mite induced allergic rhinitis or allergic asthma differ according to severity of symptoms (for example, mild, moderate, severe)?   + How is disease severity assessed in these populations?   Based on treatment needs  **Are the outcomes listed appropriate?**  **Suggest include ICS dose reduction**  **Suggest remove ‘overall survival’**  **Are there any subgroups of people in whom SQ HDM SLIT is expected to be more clinically effective and cost effective or other groups that should be examined separately?**  **No**  Where do you consider SQ HDM SLIT will fit into the existing NICE pathway, [Asthma](https://pathways.nice.org.uk/pathways/asthma)?  This consultation will look into if HDM SLIT is cost-effective and if it has a role in the existing NICE pathway for the management of allergic asthma caused by HDM. However HDM sensitisation does not always indicate that asthma is driven by HDM | Comment noted. The committee will consider any potential issues relating to the evidence presented. No action required.  Comments noted. Please see other sections of this document for relevant responses. |