

**NATIONAL INSTITUTE FOR HEALTH AND CARE
EXCELLENCE**

Appraisal consultation document

**Ocrelizumab for treating primary progressive
multiple sclerosis**

The Department of Health and Social Care has asked the National Institute for Health and Care Excellence (NICE) to produce guidance on using ocrelizumab 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?

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 ocrelizumab 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: 19 July 2018

Second appraisal committee meeting: 2 August 2018

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

1 Recommendations

- 1.1 Ocrelizumab is not recommended, within its marketing authorisation, for treating early primary progressive multiple sclerosis with imaging features characteristic of inflammatory activity in adults.
- 1.2 This recommendation is not intended to affect treatment with ocrelizumab 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

There are currently no disease-modifying treatments approved for primary progressive multiple sclerosis. Clinical trial results show that ocrelizumab can slow the worsening of disability in people with the condition, including loss of upper limb function.

However, the most plausible cost-effectiveness estimates for ocrelizumab compared with best supportive care alone are much higher than those NICE normally considers an acceptable use of NHS resources in all scenarios presented by the company. Therefore, ocrelizumab cannot be recommended for treating early primary progressive multiple sclerosis in adults.

2 Information about ocrelizumab

Marketing authorisation indication	Ocrelizumab (Ocrevus, Roche) has a marketing authorisation in the UK 'for the treatment of adult patients with early primary progressive multiple sclerosis (PPMS) in terms of disease duration and level of disability, and with imaging features characteristic of inflammatory activity'.
Dosage in the marketing authorisation	Ocrelizumab is administered by intravenous infusion. The first dose is administered as 2x300 mg infusions 2 weeks apart; subsequent doses are administered as a single 600 mg infusion every 6 months. There should be a minimum interval of 5 months between each dose.
Price	The list price for ocrelizumab is £4,790 per 300 mg vial (company submission). The company has a commercial arrangement which would apply if the technology had been recommended.

3 Committee discussion

The appraisal committee (section 5) considered evidence submitted by Roche and a review of this submission by the evidence review group (ERG). See the [committee papers](#) for full details of the evidence.

The condition and current care pathway

Primary progressive multiple sclerosis has a substantial effect on the lives of people with the condition and their families

3.1 There are currently no disease-modifying treatments approved for primary progressive multiple sclerosis. So, unlike for relapsing–remitting multiple sclerosis, clinicians can only offer interventions designed to control symptoms. The patient experts explained that having a diagnosis of primary progressive multiple sclerosis often helps people understand the cause of their symptoms, but learning that there are no treatment options to slow the disease process can cause anxiety. The experts further commented that people with the condition often have to reduce work commitments and may be unable to continue their usual daily activities.

They highlighted the loss of confidence and depression that this causes,

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and noted that people feel the condition reduces what they are able to contribute to society. The committee also noted the submissions it had received from patient and carer organisations. These detailed how many people with primary progressive multiple sclerosis eventually need support and care from family members or friends. The committee concluded that primary progressive multiple sclerosis can substantially affect the lives of people with the condition and their families, and that disease-modifying treatments for this condition would be welcome.

Slowing disability progression and preserving upper limb function allow people to continue working, engage in everyday activities and self-care

3.2 A patient expert explained that, after starting treatment with ocrelizumab, his condition had improved. This had allowed him to keep working, particularly because of the treatment's effect on his upper limb function. In addition, patient and clinical experts explained that preserving upper limb function is important because it allows people to continue to care for themselves and reduces their reliance on others. The clinical experts noted that it is important to preserve upper limb function in all forms of multiple sclerosis. The committee noted that slowing disability progression allows people to stay in work and engage in everyday activities for longer than they may have done without treatment. It concluded that slowing disability progression and preserving upper limb function will allow people with primary progressive multiple sclerosis, as with other forms of multiple sclerosis, to continue working, engage in everyday activities and care for themselves for longer.

Diagnosing the condition is difficult and identifying who will benefit from ocrelizumab is likely to increase demand for MRI scans

3.3 The clinical experts explained that diagnosing primary progressive multiple sclerosis is difficult because of the gradual, progressive nature of the condition, and the initial non-specific symptoms. In addition, it is hard to determine the time since onset of the condition because there is often no clear initial event. NICE must appraise drugs within the confines of the

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marketing authorisation determined by the regulators. The committee noted the marketing authorisation, which the ERG considered 'vague and subjective', limits treatment to early primary progressive multiple sclerosis with imaging features that are characteristic of inflammatory activity. The committee was aware that to do this either a single T1 MRI scan with a contrast agent (gadolinium) to identify acute inflammatory lesions, or at least 2 T2 MRI scans to identify new or enlarging lesions, would be needed. A clinical expert explained that use of gadolinium is reducing because of concerns over longer-term safety, but that T2 scans could be used to identify inflammatory activity because they can be used to monitor change and do not rely on an active lesion being present at the time of imaging. The company included the cost of an MRI scan, without contrast, per person treated with ocrelizumab in the economic model, and the cost of a further MRI scan, without contrast, for 70% of people (assuming that 30% of people with primary progressive multiple sclerosis would have had a suitable MRI scan already). A patient expert commented that repeated MRI scans are not currently done to monitor inflammatory activity because no disease-modifying treatments are available for primary progressive multiple sclerosis. The committee therefore concluded that the use of ocrelizumab is likely to result in increased demand for MRI scans.

Clinical effectiveness

It is appropriate to use data from the 'MRI-active' subgroup rather than from everyone in the ORATORIO trial

- 3.4 The company used the ORATORIO trial to provide data on the efficacy of ocrelizumab to treat primary progressive multiple sclerosis. ORATORIO was a double-blind placebo-controlled trial including 732 people from 29 countries. The committee noted that it did not enrol people aged over 55 years. A clinical expert commented that this is generally the case for multiple sclerosis trials, and that the results could be considered generalisable to people in this age group. The committee further noted that the marketing authorisation for ocrelizumab was narrower than the

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inclusion criteria for the ORATORIO trial (that is, the entire or intention-to-treat population). The company explained that it had provided a post-hoc subgroup analysis of people in the ORATORIO trial with gadolinium-enhancing T1 lesions at screening or baseline, or with new T2 lesions between screening and baseline, to match the specification in the marketing authorisation for 'imaging features characteristic of inflammatory activity' (MRI-active subgroup). The committee noted that the study was powered for the intention-to-treat population, rather than this group, so the real difference in treatment may have been missed. The clinical experts explained that the company's method of identifying people with imaging features characteristic of inflammatory activity met accepted clinical definitions. The committee concluded that it was appropriate to use data from the MRI-active subgroup from ORATORIO for decision-making.

Defining early primary progressive multiple sclerosis is difficult in NHS practice

3.5 The marketing authorisation for ocrelizumab also includes restricting treatment to primary progressive multiple sclerosis that is 'early' in terms of duration and level of disability. The company considered that everyone enrolled in the ORATORIO trial met this definition; specifically, the trial included only people who, at screening, had:

- an expanded disability status scale (EDSS) score from 3.0 to 6.5 points
- a time since onset of symptoms of
 - less than 15 years if the EDSS score was more than 5.0 or
 - less than 10 years if the EDSS score was 5.0 or less.

The committee noted that the European Medicines Agency (EMA) had defined early primary progressive multiple sclerosis in the summary of product characteristics with reference to the main inclusion criteria of the ORATORIO study. The clinical experts considered this too long since onset of the condition for people to be considered as having early primary

progressive multiple sclerosis, and that there is no clear definition of early disease. The ERG commented that the clinical experts it had consulted suggested that they would define early disease as being within 5 years of symptom onset. The committee concluded that defining 'early' disease in NHS practice is difficult but that, for the purpose of this appraisal, early primary progressive multiple sclerosis is as defined by the EMA for the marketing authorisation.

It is not appropriate to limit analyses and guidance to people aged 50 years or younger

3.6 The company provided clinical data from a subgroup of the MRI-active subgroup limited to people aged 50 years or younger, and modelled the cost effectiveness of ocrelizumab for this subgroup. The committee was aware that the marketing authorisation does not specify an age threshold for treatment. It concluded that, in the absence of a clear biological rationale to exclude data from patients aged 50 to 55 years, it was not appropriate to define an age limit in this guidance.

Confirmed disease progression at 24 weeks is preferable to that at 12 weeks

3.7 The primary endpoint in the ORATORIO trial was time to disease progression confirmed after 12 weeks (CDP-12), and time to disease progression confirmed after 24 weeks (CDP-24) was a secondary endpoint. People randomised to ocrelizumab in the MRI-active subgroup were statistically significantly less likely to have CDP-12 than people randomised to placebo. In the MRI-active subgroup, the treatment effect was slightly larger for CDP-12 (hazard ratio 0.68; 95% confidence interval 0.46 to 0.99) than for CDP-24 (hazard ratio 0.71; 95% confidence interval 0.47 to 1.06). The clinical experts commented that there is no consensus on what a 'clinically significant' effect is because there is no precedent for treating primary progressive multiple sclerosis. The committee noted that, in previous appraisals for relapsing–remitting multiple sclerosis, disability confirmed at 24 weeks (6 months) had been preferred to disability confirmed at 12 weeks (3 months), and considered whether there were

any reasons why this should not apply to primary progressive multiple sclerosis. A clinical expert commented that there was no reason why confirming disability after a longer period would not be more reliable than a shorter period of time in this type of multiple sclerosis. The committee concluded that it preferred analyses using confirmed disability progression after 24 weeks over confirmed disability progression after 12 weeks.

Cost effectiveness

It is appropriate to include costs, disutilities and a treatment effect associated with relapses in the economic model

3.8 The clinical experts explained that relapses do occur in primary progressive multiple sclerosis but are not characteristic of the condition in the way that they are for relapsing–remitting multiple sclerosis. The company excluded costs, disutilities and a treatment effect associated with ocrelizumab for relapses in its base-case model. The committee concluded that it would have been appropriate for the company to include costs, disutilities and a treatment effect associated with relapses in its base-case analysis.

Adverse events

Progressive multifocal leukoencephalopathy (PML) is a possible adverse event associated with ocrelizumab

3.9 The committee questioned why the company had not included adverse events related to infection in the model, given that a high proportion of people in both the treatment (70%) and placebo (68%) arms of the ORATORIO trial had experienced this event. The company explained that it had focussed on 1 specific infection (upper respiratory tract infection), which occurred with the largest difference in frequencies between the ocrelizumab and placebo arms. The company explained that it could assign specific costs and utility values to upper respiratory tract infection, but not to aggregated infections. The committee also questioned why the

company had not included PML in its model, noting that this had been considered as relevant in an ongoing appraisal of ocrelizumab for relapsing–remitting multiple sclerosis. The company commented that it had included PML as an adverse event in an updated model for the relapsing–remitting MS appraisal. However, the company did not think this was appropriate for this population because cases of PML in people with relapsing–remitting MS treated with ocrelizumab can potentially be attributed to previous disease-modifying treatments, and because there have not yet been any recorded cases of PML after treatment with ocrelizumab in people with PPMS. The clinical experts commented that PML is related to the treatment rather than the condition, and it would be inconsistent to consider that PML could occur in 1 type of multiple sclerosis, but not the other. The committee concluded that there may be a risk of PML following treatment with ocrelizumab, and that, if so, the economic model should have included this risk for ocrelizumab.

There are concerns about using the MSBase registry data to inform baseline transitions between EDSS states

- 3.10 To inform the progression of disability between EDSS states in the absence of treatment, the company chose not to use data from the placebo group of the ORATORIO trial but instead used data from a disease registry (MSBase) in its model. The company explained that it had used registry data because they reflect a larger population over a longer follow-up period. It also explained that it had not chosen to use registries that have been used in previous relapsing–remitting multiple sclerosis appraisals, such as the London Ontario registry, because these included few people with primary progressive multiple sclerosis. The ERG highlighted that MSBase was not restricted to people with primary progressive multiple sclerosis who had MRI scans showing inflammatory activity. The company acknowledged that limited MRI data are available from the MSBase registry, and the clinical experts confirmed this. Moreover, the clinical experts commented that a lot of data in the MSBase

registry come from Eastern Europe, where the definition of primary progressive multiple sclerosis may differ from the UK. The committee concluded that it had concerns about using data from the MSBase registry to inform baseline transitions between EDSS states in the absence of treatment in the company's model, and considered that its use was associated with uncertainty.

Waning of treatment efficacy

Treatment efficacy may wane over time with ocrelizumab, but the absolute rate of waning is uncertain

3.11 The company assumed in its base case that the relative treatment effect of ocrelizumab did not wane over time (that is, it worked equally well early and late in the course of treatment). It assumed this because ocrelizumab generates few neutralising antibodies, and because there was a sustained treatment effect with the drug in an open-label extension of a trial in relapsing–remitting multiple sclerosis. The company also assumed that people would stop taking ocrelizumab if they no longer gained any benefit from it. Therefore, the company considered that including all-cause stopping of treatment in the economic model (see section 3.12) would act as a proxy for any waning of treatment effect. The ERG considered it implausible that there is no waning of treatment effect. This was because treatment effect fluctuated over the course of the ORATORIO trial, and there was no evidence to show a long-term sustained effect. The ERG therefore included treatment waning in its base case, implementing it by reducing the treatment effect of ocrelizumab on slowing disease progression between EDSS states by 50% after 5 years. The ERG explained that it considered this approach to be the most appropriate based on those used in previous relapsing–remitting multiple sclerosis NICE technology guidance appraisals. The committee noted that, in an ongoing appraisal for ocrelizumab for relapsing–remitting multiple sclerosis, the committee considered that treatment efficacy likely wanes over time. The committee concluded that the company's assumption of no

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waning of treatment effect was too optimistic, but that the ERG's approach may be too pessimistic. It concluded that the true waning of treatment effect is likely to lie between these 2 approaches.

Stopping treatment

There is considerable uncertainty about how long people would continue to take ocrelizumab

3.12 The company modelled all-cause stopping of treatment (because of adverse events or because it does not work) by fitting a Gompertz distribution to data from the whole population rather than the MRI-active subgroup in ORATORIO. However, the company stated that clinical opinion considered the average treatment duration predicted by this model to be too high (about 7.0 years). It provided what it considered a more realistic scenario analysis with a higher (constant) treatment withdrawal rate, which predicted an average treatment duration of about 4.5 years. The ERG also used a Gompertz model in its base case, and considered that the rate of stopping treatment would rise as the effect of ocrelizumab waned (after 5.0 years; see section 3.11), adding this to its base case. The committee concluded that including both stopping and, separately, waning in the ERG's base case may have overestimated the rate of stopping treatment.

There is considerable uncertainty about an appropriate stopping rule for disease-modifying therapies for primary progressive multiple sclerosis

3.13 Both the company and ERG had assumed in their base cases that ocrelizumab treatment would stop when people progressed to an EDSS stage 8.0. The clinical experts commented that this was later than when people stop disease-modifying treatments in relapsing–remitting multiple sclerosis, which is when a patient has an EDSS stage 7.0 for more than 6 months. The clinical experts commented that an argument can be made for continuing treatment to an EDSS stage 8.0 because preserving upper limb function is particularly important once people are unable to walk.

However, this argument would apply equally to people with relapsing–remitting multiple sclerosis. The clinical experts noted that the ORATORIO trial enrolled people with an EDSS only up to stage 6.5, so there is no evidence for efficacy when starting treatment beyond this stage. The committee concluded that there is considerable uncertainty and did not see evidence to support a stopping rule that differed by type of multiple sclerosis. It would welcome comments on what an acceptable stopping rule would be during consultation.

Utility values

Utility values from Orme et al. (2007) should be used for all EDSS states

3.14 The company used utility values derived from the ORATORIO trial for most EDSS states in its base case. For EDSS states for which ORATORIO offered no data (0, 1, 8 and 9), the company used utility values specific to primary progressive multiple sclerosis from MS Trust survey data (Orme et al.). The committee noted that the utility values from ORATORIO were higher than those from Orme et al. and another primary progressive multiple sclerosis study (Hawton and Green, 2016). The company suggested that this was because people in the ORATORIO trial were younger (mean age 44 years) than in the other studies. The committee noted that the population that its recommendations would apply to would include people aged over 55 years who are not represented in ORATORIO. It also preferred using utility values from a single source, rather than using different sources for different EDSS states. The committee concluded that using utility values for the EDSS states from Orme et al. was preferable.

It is not appropriate to include additional utility decrements for upper limb dysfunction and fatigue

3.15 In addition to applying different utility values for each EDSS state, in its base-case model, the company also applied a utility decrement to each EDSS state for people with upper limb dysfunction and those with

clinically meaningful fatigue. The company did this because its analysis on data from ORATORIO showed that these factors affected health-related quality of life independent of EDSS state. The ERG disagreed with including additional utility decrements in the model, and did not include them in its own base case. This was because ocrelizumab had no effect on reducing fatigue (based on change in baseline score) in the MRI-active subgroup. Also, the company used cut-offs on the Modified Fatigue Impact Scale (MFIS) to define people as having clinically meaningful fatigue. However cut-offs are not normally used with fatigue scores and most people entering the ORATORIO trial had fatigue based on the company's definition. The ERG also highlighted that previous appraisals for multiple sclerosis had not used specific utility decrements for symptoms. The clinical experts commented that fatigue and upper limb function are equally important for people with relapsing–remitting multiple sclerosis. The committee noted that the company's approach would double count disutilities incorporated within the EQ-5D because the MFIS and EQ-5D questionnaires overlap in some domains. It concluded that it was inappropriate to include utility decrements from upper limb dysfunction and fatigue in the economic model.

Cost-effectiveness estimates

Ocrelizumab at its current price is not cost effective

3.16 In its base case, the company estimated the incremental cost-effectiveness ratio (ICER) for the MRI-active subgroup at the patient access scheme price as:

- £78,316 per quality-adjusted life year (QALY) gained in the deterministic model and
- £84,249 per QALY gained in the probabilistic model.

The economic analyses that included the committee's preferred inputs differed from the company's base case. The committee preferred costs,

utilities and the treatment effect associated with relapses (see section 3.8) to be included and this reduced the ICER by a small amount. Other committee preferences increased the ICER from the base-case estimates, and included:

- using confirmed disability progression after 24 weeks, rather than 12 weeks, to estimate the treatment effect of ocrelizumab on disease progression (see section 3.7)
- including the risk of PML (see section 3.9)
- using utility values for EDSS states from Orme et al. (2007; see section 3.14)
- not including utility decrements for upper limb dysfunction and fatigue (see section 3.15).

Uncertainties also remain about the true rate of treatment waning (see section 3.11), how long people would continue to take ocrelizumab (see section 3.12) and when treatment would be stopped (see section 3.13) The company commented that it did not consider ocrelizumab to be cost effective at the patient access scheme price. The committee concluded that ocrelizumab was not cost effective for treating primary progressive multiple sclerosis at the patient access scheme price.

Proposal for data collection and a commercial agreement

The commercial arrangement has not been approved by NHS England

3.17 The company presented a proposal for a commercial arrangement. It stated that this would provide ocrelizumab to the NHS at a reduced price (which is commercial in confidence) until an ongoing trial finishes. The committee understood that NHS England had not agreed to this commercial arrangement. It expressed concerns about the burden to the NHS of accommodating the proposed commercial arrangement, but agreed that it was appropriate to consider the company's proposal.

Ocrelizumab is unlikely to be cost effective for treating primary progressive multiple sclerosis at the current patient access scheme price

3.18 The committee noted that the commercial arrangement would only apply in the short term, and only to the primary progressive multiple sclerosis population, not the whole multiple sclerosis population. The committee therefore considered whether ocrelizumab was cost effective at the current patient access scheme price. The committee noted that there were no plausible scenarios presented in which ocrelizumab was cost effective at this price, and concluded that ocrelizumab is unlikely to be cost effective for treating primary progressive multiple sclerosis at the current patient access scheme price.

Data from an ongoing trial is unlikely to address the uncertainties identified by the committee

3.19 The committee reflected on the evidence presented and agreed that the driver of the decision was a lack of cost effectiveness rather than uncertainty. The company described an upcoming phase IIIb trial that was required by the EMA's Risk Management Plan for ocrelizumab. It highlighted that the study protocol is currently under development, but the committee noted that a measure of upper limb function (9-HPT) will be the primary endpoint. The committee recalled its conclusion that it is not appropriate to include a utility decrement based on upper limb function in the economic model (see section 3.15). It also noted that the trial population will include patients aged up to 65 years with an EDSS state of up to 8.0. It agreed that, while this may provide reassurance that ocrelizumab is effective in an older population and for people starting treatment at a higher EDSS stage, it is unlikely to provide the evidence needed for ocrelizumab to become cost effective (that is, evidence of a greater treatment effect than supported by the current evidence base). The committee noted that there are relatively few uncertainties in this appraisal, the most important being the extent of treatment waning and how long people would stay on treatment. It recognised that the reason for

concluding that ocrelizumab is not cost effective is because the ICERs in all presented scenarios are too high. It concluded that the proposed additional trial would not be able to allay the key uncertainties it had identified such that ocrelizumab could then be considered cost effective.

Ocrelizumab is not cost effective at the proposed commercial arrangement price

3.20 The company's base-case ICER for the MRI-active subgroup using the proposed commercial arrangement price was above £30,000 per QALY gained. Incorporating the committee's preferences for the economic analysis would further increase the ICER. The committee concluded that ocrelizumab is not cost effective either at the patient access scheme price or at the lower proposed commercial arrangement price.

Innovation

Ocrelizumab is an innovative treatment for primary progressive multiple sclerosis

3.21 The company stated that ocrelizumab is an innovative treatment because it is the only approved disease-modifying treatment for use in primary progressive multiple sclerosis. The committee noted that there is a considerable unmet need for treatment (see section 3.1) for this condition, so ocrelizumab reflected a 'step change' in treatment. The company stated that it believed its model captures all QALY benefits. The committee concluded that ocrelizumab is a 'step change' in treatment for primary progressive multiple sclerosis, but that it had not been presented with evidence of any additional benefits not captured in the QALY measurements.

Conclusion

Ocrelizumab is not recommended for treating primary progressive multiple sclerosis

3.22 Ocrelizumab slows disability progression compared with placebo, although the size and duration of the effect are uncertain. There is also a large unmet need for treatment for people with primary progressive multiple sclerosis because no disease-modifying treatments are currently approved (see section 3.1). However, cost-effectiveness estimates from the company's base-case model were far higher than those NICE normally considers an acceptable use of NHS resources. In addition, the committee had several preferences for the model that differed from the company's base case. Implementing these preferences would increase the ICER even further (see section 3.16).

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.

Amanda Adler
Chair, Appraisal Committee
June 2018

5 Appraisal committee members and NICE project team

Appraisal committee members

The 4 technology appraisal committees are standing advisory committees of NICE. This topic was considered by [committee B](#).

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.

Thomas Walker

Technical Lead

Rebecca Albrow

Technical Adviser

Donna Barnes

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