NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Appraisal consultation document

Tepotinib for treating advanced non-small-cell lung cancer with MET gene alterations

The Department of Health and Social Care has asked the National Institute for Health and Care Excellence (NICE) to produce guidance on using tepotinib 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, sex, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

Issue date: January 2022

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 tepotinib 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: 23 February 2022

Second appraisal committee meeting: 10 March 2022

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

1 Recommendations

1.1 Tepotinib is not recommended, within its marketing authorisation, for treating advanced non-small-cell lung cancer (NSCLC) with MET exon 14 (METex14) skipping alterations in adults.

1.2 This recommendation is not intended to affect treatment with tepotinib 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

Standard care for advanced METex14 skipping NSCLC is usually immunotherapy plus platinum-doublet chemotherapy (chemo-immunotherapy). People have different treatments depending on their PD-L1 tumour proportion score and whether they have squamous or non-squamous NSCLC.

Clinical trial evidence suggests a clinical benefit for tepotinib, but this is uncertain because tepotinib was not directly compared with another treatment. It has been indirectly compared with groups of other treatments, but the results of this are highly uncertain. This is particularly the case for the comparison with chemo-immunotherapy, the most widely used treatment.

The economic model is uncertain because it is unclear how much longer people having tepotinib live compared with those having standard care. There is also uncertainty around what treatments people would have after tepotinib and standard care.

Because of the problems with the company's model, it is not possible to confidently estimate tepotinib's cost effectiveness. Collecting more data in the Cancer Drugs Fund is unlikely to help to resolve the main uncertainty and tepotinib has not been

reliably shown to have potential to be cost effective. So, tepotinib is not recommended for routine use or through the Cancer Drugs Fund.

2 Information about tepotinib

Marketing authorisation indication

2.1 Tepotinib (Tepmetko, Merck) is indicated for 'the treatment of adult patients with advanced non-small cell lung cancer (NSCLC) harbouring mesenchymal-epithelial transition factor gene (MET) exon 14 (METex14) skipping alterations'.

Dosage in the marketing authorisation

2.2 The dosage schedule is available in tepotinib's summary of product characteristics.

Price

2.3 The list price of tepotinib is confidential.

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 Merck, 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.

A new targeted treatment

People with METex14 skipping NSCLC would welcome a new oral treatment option that is well tolerated

3.1 There is no defined treatment pathway specific to METex14 skipping NSCLC because there are no targeted treatments available in the UK. People with METex14 skipping NSCLC are offered the same standard

care as people with NSCLC without this specific oncogenic biomarker. These treatments include chemotherapy (such as platinum-doublet chemotherapy), immunotherapy (such as pembrolizumab) and combinations of chemotherapy and immunotherapy (chemo-immunotherapy). The clinical experts explained that people with METex14 skipping NSCLC have a poorer prognosis than people without this biomarker. They tend to be older than people with other oncogenic-driven NSCLC, and so treating this population can be challenging because of comorbidities and overall frailty. The clinical experts further explained that this population would benefit from the favourable side effect profile of tepotinib compared with chemotherapy and chemo-immunotherapy. In addition, these people would benefit from the reduced treatment administration burden offered by an oral therapy that does not need day-unit attendance, as is the case for chemotherapy and chemo-immunotherapy. The clinical experts stated that, if recommended, tepotinib would likely be offered as the first-line treatment for people with METex14 skipping NSCLC confirmed by genomic testing. They clarified that testing for METex14 skipping mutations is variable across the UK. Because of this, clinicians would continue to use other first-line treatment options until the mutation is confirmed. Tepotinib may therefore be used at other points in the treatment pathway, in line with its marketing authorisation. The committee agreed that there is a clear unmet need in this patient population. It concluded that people with METex14 skipping NSCLC would welcome a new oral treatment option that is well tolerated.

Population and subgroups

Untreated and treated subgroups should be considered separately

3.2 The company base case population comprised all people with METex14 skipping NSCLC regardless of whether or not they had had prior treatment. The NICE scope stated that the population should be addressed according to specific subgroups, if possible. These subgroups were defined as previous treatment (treated or untreated), histology

(squamous or non-squamous), and level of PD-L1 expression. This was because the comparators differed according to these subgroups. The company explained that it had presented subgroup results according to whether people were previously treated or untreated, but that its base case did not consider subgroups by treatment line or histology because of the small number of people with METex14 skipping NSCLC. The company considered that anyone diagnosed with this condition would be offered tepotinib regardless of PD-L1 expression or histology. In addition, clinical experts consulted by the company considered that the clinical effectiveness results for tepotinib in the overall population should be generalisable regardless of histology. The ERG agreed with the company that the data limitations made it difficult to present results according to true subgroups, such as histology and PD-L1. But it stressed that by presenting results for the overall population, the company had grouped together people who would be eligible for different comparator treatments. The committee agreed that the treatments recommended by NICE for NSCLC differ based on treatment line (untreated or treated), histology (squamous or non-squamous), and PD-L1 tumour proportion score (below 50%, or 50% and above). By grouping together people on the basis of having METex14 skipping NSCLC only, the company's base case analysis potentially masked any variation in treatment effect and cost effectiveness between people who would have different comparator treatments. The committee acknowledged the practical difficulties faced by the company, but did not consider that the company's approach was appropriate. It concluded that, as a minimum, it would prefer to consider the cost-effectiveness results for previously treated and untreated disease separately.

The appraisal should focus on untreated non-squamous NSCLC with METex14 skipping alterations

3.3 The clinical experts explained that most METex14 skipping NSCLC is of non-squamous histology. The committee noted that the evidence was primarily for that histology. The committee recalled that tepotinib, if

recommended, would mostly be offered to people with untreated METex14 skipping NSCLC (see section 3.1). It therefore concluded that the most appropriate approach would be to limit the appraisal population to people with untreated non-squamous METex14 skipping NSCLC, in line with the population that would have tepotinib in UK clinical practice.

Comparators

Chemo-immunotherapy is the most relevant comparator for tepotinib

3.4 The company did not compare tepotinib with the specific comparators outlined in the NICE scope. Instead, it compared tepotinib with 2 grouped treatment classes: chemotherapy and immunotherapy. This was because of the limited data available to model specific comparator treatments (see section 3.7). The company did not include chemo-immunotherapy as a comparator in the overall population. The clinical experts explained that this did not reflect UK clinical practice, where chemo-immunotherapy is the most commonly used treatment. The Cancer Drugs Fund clinical lead agreed that people with untreated non-squamous METex14 skipping NSCLC would usually have either immunotherapy (pembrolizumab monotherapy) or chemo-immunotherapy (pembrolizumab with pemetrexed and platinum chemotherapy), depending on their PD-L1 tumour proportion score. The committee concluded that chemo-immunotherapy is widely used in clinical practice and was the most relevant comparator for tepotinib.

Clinical effectiveness

The clinical evidence for tepotinib is uncertain because it is based on 1 single-arm study that may not be generalisable to NHS practice

3.5 The evidence for tepotinib comes from the VISION clinical trial. This is an ongoing, single-arm, open-label, phase 2 trial including people with advanced (locally advanced or metastatic) NSCLC with METex14 skipping mutations or MET amplification. The primary outcome of the trial

is objective response rate. Secondary outcomes include duration of response, progression-free survival, overall survival and health-related quality of life. A total of 152 people with METex14 skipping mutations were enrolled into cohort A, which provides the clinical evidence for the company's base case cost-effectiveness analysis. Cohort C was a confirmatory cohort recruited from a later time point, enrolling 123 additional people with METex14 skipping mutations. Cohort B enrolled people with MET amplification, and so this cohort is not relevant to the appraisal. The trial recruited people from Asia (23%), North America (26%) and Europe (51%), but not from any UK centres. The clinical experts noted that the response rate in VISION was higher than would be expected with current standard treatments. Objective response rate was 46.7% (95% CI: 38.6, 55.0), being slightly higher in the first-line (50.7%) than second-line population (43.4%). The median progression-free survival was 10.8 months (95% CI: 8.3, 12.4), and the median overall survival was 19.1 months (95% CI: 15.2, 22.1), with results consistent between first- and second-line. The committee agreed that VISION shows that tepotinib is clinically effective. However, it noted that the distribution of subsequent treatments in VISION meant that the results may not be generalisable to NHS clinical practice (see section 3.10). The committee concluded that basing the evidence on 1 single-arm study meant that there was uncertainty in the data for tepotinib. This was particularly because the survival data was immature, and the lack of comparative data made assessing comparative effectiveness challenging.

Using the data from cohort A plus cohort C has little effect on the results, but would be preferable

3.6 The company used the data from cohort A exclusively for its cost-effectiveness analysis. This was because the timing of the appraisal meant that the patient-level data from cohort C was only available shortly before the submission date. The committee noted that the Kaplan–Meier plots for progression-free survival and overall survival based on cohort A were almost identical to those based on cohort A plus cohort C. The

company emphasised that the patient characteristics and outcomes were very similar between cohort A and cohort A plus cohort C. It did not expect that any minor differences, such as a small improvement in median overall survival and lower median time on treatment for cohort A plus cohort C compared with cohort A, would make much difference to the cost effectiveness results. The company considered that any differences resulting from using cohort A plus cohort C would likely favour tepotinib. The ERG agreed that the differences were likely inconsequential. However, because overall survival was slightly better for cohort A plus cohort C than cohort A alone, using this data could slightly increase the likelihood that tepotinib would be cost effective. The committee agreed that using the data from cohort A was acceptable, and that the data from cohort A plus cohort C would have little effect on the results. However, it concluded that if the data from cohort A plus cohort C could be used in the cost-effectiveness analysis, then this would be preferable.

The indirect treatment comparisons results are highly uncertain

3.7 Because VISION is a single-arm trial, indirect treatment comparisons were needed to establish the relative efficacy of tepotinib. There was no comparator clinical trial data in METex14 skipping NSCLC, so the company developed a real-world cohort from patient-level data specifically for NSCLC with this genetic biomarker. The company took this data from 3 non-interventional studies it had done: NIS-0015, NIS-0035 and COTA. Further data from people with METex14 skipping NSCLC was available from a study by Wong et al. (2021), which the company also used. NIS-0015 comprised complete data on 39 people with MET mutations from a US electronic medical records database. NIS-0035 comprised data on 86 people with MET mutations from electronic medical records from a variety of countries, but not from the UK. COTA comprised 202 complete patient records with at least 1 data point from a real-world database from the US and Canada. Wong et al. was a retrospective review of treatments and outcomes for 41 people with METex14 skipping mutations in Canada. Because patient numbers were too small to compare tepotinib with all the

individual comparators in the NICE scope, the company did indirect treatment comparisons of tepotinib with 2 grouped treatment classes: chemotherapy and immunotherapy. Very few people had chemo-immunotherapy in the real-world cohort. So, the company estimated survival for people with untreated METex14 skipping NSCLC having chemo-immunotherapy by applying hazard ratios from KEYNOTE-189 to the chemotherapy survival curves derived from its real-world cohort (see section 3.9). KEYNOTE-189 was a trial of pembrolizumab plus chemotherapy compared with chemotherapy in people with advanced non-squamous NSCLC without EGFR and ALK mutations. The company noted that its approach of using grouped comparators had been used in previous submissions to NICE in NSCLC and other oncology indications. It applied the same inclusion and exclusion criteria as used in the VISION trial to the real-world patient data to form a comparable dataset. The company used propensity scoring to achieve a balance of patient characteristics between tepotinib and the 2 grouped comparators, and to adjust for possible confounding. Sixty-six people treated with chemotherapy and 51 people treated with immunotherapy were available to conduct the indirect treatment comparisons. The ERG agreed that propensity scoring was the most appropriate method to adjust the indirect treatment comparisons. The committee noted that the company's real-world cohort did not include any people from the UK. The clinical experts explained that the treatments received, and subsequent treatments, did not match the treatments that are used in the UK. This was particularly the case for the low number of people having chemo-immunotherapy in the real-world cohort. The results of the indirect treatment comparisons showed that tepotinib had a statistically significant progression-free survival benefit compared both with chemotherapy and with immunotherapy. Tepotinib did not have a statistically significant overall survival benefit compared with either chemotherapy or immunotherapy. The clinical experts considered that the overall survival results from the indirect treatment comparisons did not reflect what would be expected in

clinical practice, particularly for chemotherapy. The committee agreed that the results of the indirect treatment comparisons were inconsistent and counter to expectations, with chemotherapy sometimes appearing to be more effective than immunotherapy. This could be partially explained by a lack of generalisability to the UK population, because of the mix of comparator treatments and because people in VISION and from the matched comparator cohort were fitter than would be seen in UK clinical practice. The indirect treatment comparisons were also based on small sample sizes, and may also not have been robust for other unknown methodological reasons. However, the committee considered that it was possible that tepotinib does not improve overall survival compared with chemotherapy or immunotherapy. The clinical experts and Cancer Drugs Fund clinical lead suggested that the company could consider basing the indirect treatment comparisons on data from comparator trials in people without specific oncogenic biomarkers. This may be more robust as it would allow larger comparator patient numbers. The committee agreed that these analyses may have value, but acknowledged that there would be uncertainty because the comparator trial populations would be different to that of tepotinib. The committee concluded that the results of the indirect treatment comparisons were highly uncertain. Because chemo-immunotherapy was the most relevant comparator (see section 3.4), the committee would also have liked to have seen a more robust indirect treatment comparison of tepotinib with chemo-immunotherapy.

The company's economic model

The structure of 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 ERG agreed with the choice of model, but explained that a state-transition model may have offered benefits. The committee concluded that the model was

generally appropriate and consistent with the models used in other appraisals for NSCLC.

The comparator overall survival extrapolations are implausible, particularly for chemotherapy and chemo-immunotherapy

3.9 To extrapolate survival beyond the data collection period, the company produced Kaplan–Meier curves from the VISION trial data for tepotinib and from the real-world cohort data for the comparators. The company then fitted different parametric survival models, piecewise models and spline models to the individual patient data. It considered statistical fit, visual assessment, and expert opinion on the clinical plausibility of the long-term survival profile to select the most plausible extrapolations. The clinical experts consulted by the company considered that the best models according to statistical fit either under- or overestimated survival for the comparators. For this reason, the company's clinical experts selected alternative survival models. The ERG explained that the company's clinical expert elicitation was likely to have introduced some bias. It noted that the comparative efficacy of tepotinib was highly dependent on the choice of extrapolations, and that fitting them independently for each comparator added uncertainty. To explore the uncertainty, the ERG produced alternative (but not preferred) scenarios using extrapolations based only on statistical fit. The company responded that it did not consider any bias to have been introduced by seeking clinical expert opinion. It noted that such opinion was critical to establishing the clinical plausibility of the extrapolations. In response to technical engagement, the company referenced external sources to validate its choice of extrapolations, such as trials in wild-type NSCLC and published real-world studies in METex14 skipping NSCLC. The clinical experts at the committee meeting had considerable concerns over the long-term overall survival estimates for the comparators. They agreed that they were higher than would be seen in NHS clinical practice, particularly for chemotherapy and chemo-immunotherapy. They explained that it was implausible for the extrapolations to have such extended tails in this

population. The committee noted that in the ERG's alternative chemotherapy overall survival extrapolation, there were more people alive after 5 years than in the company's analysis. Based on the feedback from the clinical experts, the committee agreed that the ERG's alternative extrapolations were less plausible than those of the company. However, the committee considered that the company's comparator overall survival extrapolations were also likely overestimates. The committee concluded that the comparator overall survival extrapolations were implausible, particularly for chemotherapy and chemo-immunotherapy.

Separate subsequent treatment distributions based on prior treatment status, and for people having chemo-immunotherapy, are needed

3.10 Subsequent treatment costs were applied in the company model as a one-off average cost per patient after disease progression. For its base case, the company used subsequent treatment distributions from VISION for tepotinib and from the real-world cohort for the comparators. This matched efficacy and costs in the model. The company also provided a scenario analysis for subsequent treatments using UK distributions estimated based on clinical expert input. But this only impacted the costs and not the clinical outcomes in the model, so the company considered that it was an unfair comparison. The clinical experts stated that the UK distributions estimated by the company better reflected NHS clinical practice than those based on VISION and the real-world cohort. This was because in the latter some people had crizotinib as a subsequent treatment, which is not used in this population in the UK. However, the clinical experts noted that separate distributions were needed for people having chemo-immunotherapy and based on prior treatment status. They noted that the subsequent treatment distribution for people having chemo-immunotherapy would likely be very different to that of those having immunotherapy. The committee understood that the cost-effectiveness results were highly sensitive to the subsequent treatment assumptions. Because the difference in clinical effectiveness of tepotinib compared with immunotherapy in the model was relatively small, differences in total costs

become more important to the cost-effectiveness of tepotinib. The committee agreed that the subsequent treatment assumptions were important because they had a large effect on the total costs. The committee concluded that the subsequent treatment assumptions were uncertain, but should reflect NHS clinical practice. It also agreed that separate subsequent treatment distributions were needed based on prior treatment status, and for people having chemo-immunotherapy.

There is uncertainty about the most appropriate time-on-treatment model for tepotinib, but the company's base case is likely appropriate

3.11 The company followed a similar process for extrapolating time on treatment as it did for extrapolating survival (see section 3.9). The company chose the generalised gamma curve for tepotinib despite the exponential and log-logistic models having the best statistical fit. The company explained that this was because the extended tail in the Kaplan–Meier plot was an artefact of patient censoring, and that clinical expert opinion suggested that almost nobody would be having tepotinib after 5 years. The ERG explained that other models were tried at technical engagement, but none were better fitting than the parametric models originally explored by the company. It suggested that the generalised gamma curve chosen may be the most appropriate model, but that the choice was associated with considerable uncertainty. The committee concluded that the generalised gamma model was likely to be appropriate, but that this choice was uncertain.

End of life

Life expectancy for people with METex14 skipping NSCLC is likely to be less than 2 years in the overall population

3.12 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 suggested that life expectancy for people having chemotherapy in the overall population was less than

2 years, but not for people having immunotherapy. It explained that this was supported by literature data, data from the indirect treatment comparisons, and from the model extrapolations. The company also considered that life expectancy was less than 2 years for people having either chemotherapy or immunotherapy in the previously treated subgroup for the same reasons. The median life expectancies from the indirect treatment comparisons and the mean life expectancies from the model are academic in confidence and cannot be reported here. The committee recalled that neither the indirect treatment comparison results or overall survival extrapolations could be considered robust. But, it noted that they both likely overestimated overall survival for the comparators. The committee understood from the clinical experts that life expectancy for these people is likely to be less than 2 years, regardless of treatment. Because it would prefer to consider the cost-effectiveness results for previously treated and untreated disease separately (see section 3.2), the committee concluded that although life expectancy for people with METex14 skipping NSCLC is likely to be less than 2 years in the company's base case population, this would not be used to inform its decision-making on the end-of-life criteria.

It is uncertain whether tepotinib extends life by more than 3 months, so it does not meet the end-of-life criteria

3.13 The clinical experts felt that it was clinically plausible that tepotinib extends overall survival to some extent. However, the committee noted that the indirect treatment comparisons did not show a statistically significant overall survival benefit for tepotinib, and that the confidence intervals were wide. It was also cautious about using the model extrapolations for decision making because they likely did not accurately predict overall survival for the comparator treatments (see section 3.9). The committee agreed that because of the uncertainty in the data and the lack of a statistically significant overall survival benefit for tepotinib from the indirect treatment comparisons, the estimates of the extension to life for tepotinib were not sufficiently robust. The committee concluded that

there was not sufficient evidence to indicate that tepotinib offers an extension to life of at least 3 additional months compared with current NHS treatment. So, tepotinib does not meet the end-of-life criteria.

Cost-effectiveness estimates

A plausible ICER could not be determined because of problems with the company's modelling approach and uncertainty in the model parameters, so tepotinib is not recommended for routine use

3.14 The committee agreed that there were problems with the company's modelling approach in terms of the comparators used and modelling of comparator effectiveness. It noted the high level of uncertainty in the model, particularly around:

- the results of the indirect treatment comparisons (see section 3.7)
- the comparator overall survival extrapolations (see section 3.9)
- the subsequent treatment distributions (see section 3.10).

Because of this, the committee did not consider the base cases presented by either the company or ERG to be suitable for decision making. So, it could not select a most plausible incremental cost-effectiveness ratio (ICER) or range of ICERs on which to base a decision. Tepotinib is therefore not recommended for routine use in the NHS.

Cancer Drugs Fund

Tepotinib is not recommended for use in the Cancer Drugs Fund

3.15 Having concluded that tepotinib could not be recommended for routine use, the committee then considered if it could be recommended 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). It considered whether the uncertainties in the company's modelling could be addressed through collecting more data. The committee was aware that VISION was

ongoing, and that more mature overall survival and progression-free survival data would be available for tepotinib. It also understood that the company had 2 additional observational studies of tepotinib planned. The committee considered that additional data from the Cancer Drugs Fund would likely resolve some of the modelling uncertainties, but it would not robustly resolve the uncertainty around the comparative effectiveness of tepotinib. The committee also noted that it had not concluded that tepotinib had plausible potential to be cost effective. It concluded that tepotinib did not meet the criteria to be considered for inclusion in the Cancer Drugs Fund.

Other factors

3.16 No relevant equalities issues were identified.

3.17 The committee noted that tepotinib is an oral drug, and it specifically targets METex14 skipping NSCLC. It understood from the clinical expert and patient expert feedback that tepotinib would be an improvement over the current treatments, and agreed that tepotinib would be beneficial. The committee considered that the model structure should have been able to capture the benefits and costs of tepotinib in terms of health-related quality of life and quality-adjusted life years (QALYs) gained. It had not been presented with evidence of any additional benefits that were not captured in the QALY calculations.

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.

Megan John
Chair, appraisal committee
January 2022

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 D.

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.

Luke Cowie
Technical lead

Charlie Hewitt
Technical adviser

Kate Moore
Project manager

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